Legacy Health System

INTERVENTIONAL RADIOLOGY REFERRAL FORM

Phone: (503) 413-4330 Fax: (503) 413-4349

Preferred Hospital Location:

- ❑ Legacy Emanuel Medical Center/Randall Children's Hospital
- ❑ Legacy Good Samaritan Medical Center
- ❑ Legacy Mount Hood Medical Center

Reason for Referral: (Check boxes)

- ❑ Biliary drainage and stenting
- ❑ Cancer diagnosis and treatments
    - ❑ Imaging guided Biopsy
    - ❑ Radiofrequency ablation (RFA)
    - ❑ Chemoembolization
- ❑ Deep Vein Thrombosis (DVT) treatment
- ❑ Endobiliary intervention
- ❑ Intra-arterial cancer treatment
- ❑ Kyphoplasty
- ❑ Peripheral Vascular Disease diagnosis and treatment
- ❑ Transjugular intrahepatic portosystemic shunt (TIPS)
- ❑ Uterine fibroid/artery embolization
- ❑ Venous access
- ❑ Image Guided Biopsy: ___________________________
  ____
- ❑ Other: ____

Referring Physician Information:

Ordering Physician:____

Address:____

Telephone:______________________________ Fax:____

Office contact:___________________________ Phone:_______________________________________

Patient Information:

Name of Patient:____

Sex: ❑ Female ❑ Male Date of Birth: ________________ Best contact #: ____________________

Insurance: ____

Is the patient on blood thinners? ❑ Pradaxa ❑ Coumadin/Warfarin ❑ Aspirin ❑ Other

Has patient had previous imaging? ❑ Yes ❑ No

If yes, where? ❑ Legacy ❑ Other:____

Please fax the following information with this request to 503-413-4349

❑ Demographics ❑ Copy of Insurance Card ❑ Diagnostic imaging

❑ History and Physical ❑ Medication List

12/2020