CARDIOVASCULAR AND INTERVENTIONAL ASSOCIATES

ASSOCIATION OF ALEXANDRIA RADIOLOGISTS, PC

INTERVENTIONAL ONCOLOGY REFERRAL FORM

Patient Name _____ Date of Birth _____ MRN_____

Referring Physician _____ Signature _____

Duplicate Report(s) To _____

Clinical History: _____

Comments/Special Instructions:_____

ALL PERTINENT IMAGING MUST BE REVIEWED BY THE INTERVENTIONAL RADIOLOGIST PRIOR TO SCHEDULING

IMAGE-GUIDED ASPIRATION ☐Thoracentesis ☐Paracentesis

☐Diagnostic ☐Therapeutic ☐Right ☐Left ☐IR Discretion

IMAGE-GUIDED BIOPSY ☐Specific Location(s): _____ ☐IR Discretion

☐Lung ☐Liver ☐Kidney ☐Lymph Node ☐Bone Marrow ☐Mass

INTERVENTIONAL ONCOLOGY CONSULTATION

☐Lesion Location(s): _____

- ☐Ablation (cryoablation, microwave ablation, NanoKnife®)
- ☐Embolization (bland, chemoembolization/TACE, radioembolization/Y-90)
- ☐Spine Ablation
- ☐Pain management (i.e. tumor debulking, celiac plexus block)

VENOUS ACCESS

☐Mediport placement

☐Mediport removal

☐PICC

☐Tunneled central venous catheter

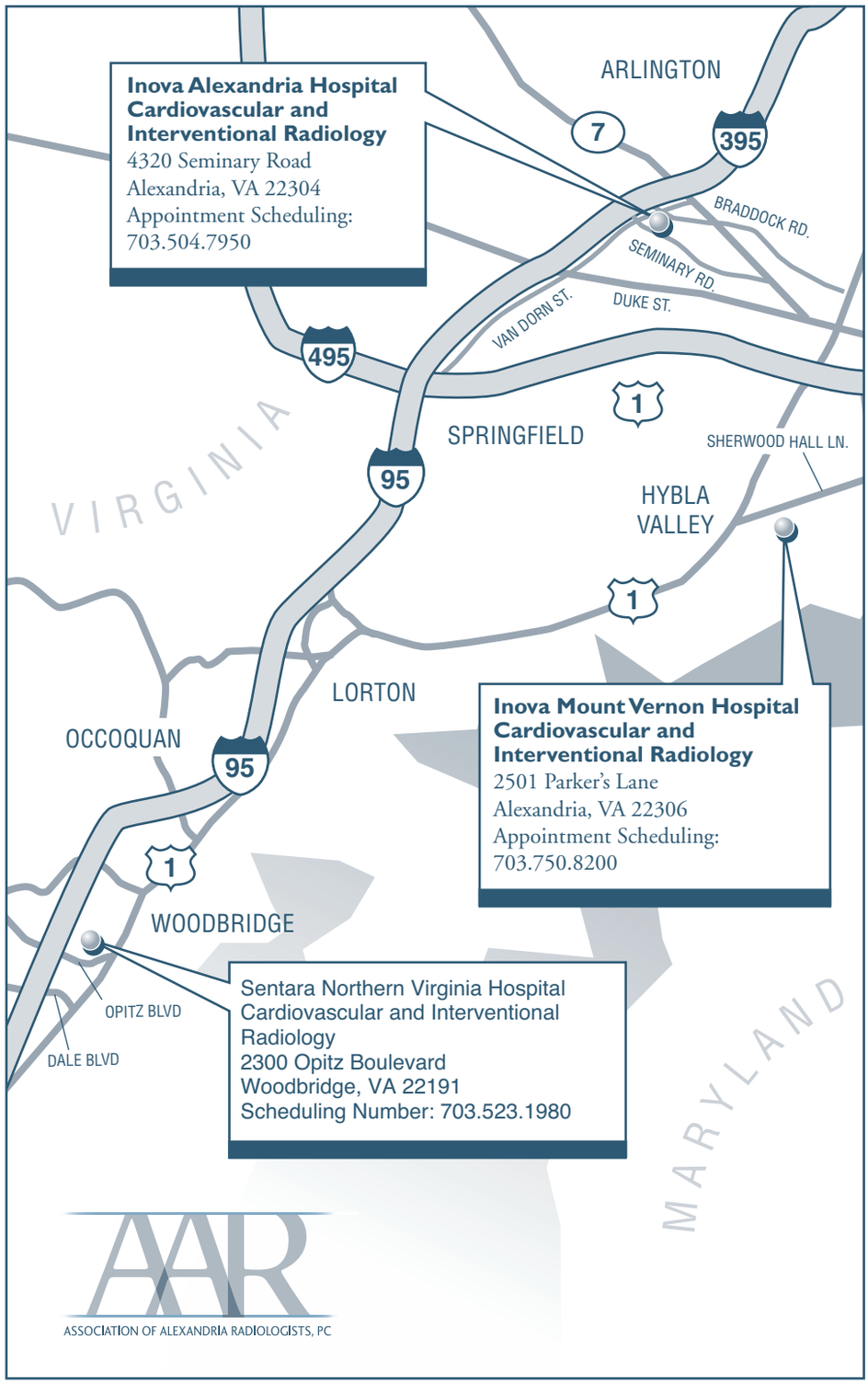
OTHER PROCEDURES

☐Gastrostomy placement

☐Intrathecal Chemotherapy

☐Tunneled pleural catheter placement

☐Tunneled peritoneal catheter placement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HYBLA
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AAR
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