Inova Fairfax Hospital
Interventional Neuroradiology – Referral Form

IMPORTANT: Please fax this form, the Doctor's order, PMH, medication list and office notes ASAP and have the patient bring the originals.

PATIENT INFORMATION

Date: ______________________ MRN#_______________________

Referring Dr.:________________________________ Office #:______________ Fax #:______________

Patient's name: ______________________________ DOB: ______________________________________

Home phone #: ______________________________ Work phone #: ______________________________

Patient's email address (if applicable): ____

ORDER INFORMATION

REASON FOR EXAM: ____

Diagnosis/symptoms: ____

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Allergies: ______________________________ **Iodine/Contrast Allergy:** ____________________________

Is the patient on anticoagulation? ____

Procedure You are Requesting:

______ Consult
______ Cerebral angiogram
______ Test occlusion
______ Possible embolization
______ Vertebroplasty
______ Other: ______________________________

When do you need this procedure done? _________________________________

What imaging has been done? ____

Where can we obtain images? ____

Recent lab work? ___ No ___ Yes

If yes, where can we obtain lab work? ____

Insurance information: ____