



# Interventional Oncology Patient Referral Form

Appointment Date \_\_\_\_\_  
Appointment Time \_\_\_\_\_  AM  PM  
Appointment Location \_\_\_\_\_

**Please fill out the information below and fax it to 704.446.4301  
OR you may call in an appointment at 704.355.1322.**

## Patient & Practice Information:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_  
(please also fax copy of insurance card)

Clinical Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Ref. Physician Signature: \_\_\_\_\_

Referring Physician Location: \_\_\_\_\_

Referring Physician Phone Number: \_\_\_\_\_

Contact or RN: \_\_\_\_\_

**Please indicate which procedure you are ordering:**

### Tumor Ablation

- RFA (Radiofrequency Ablation)
- Microwave Ablation
- Cryo Ablation
- Liver       Kidney
- Lung       Other: \_\_\_\_\_

### Primary and Metastatic Liver Cancer Procedures

- Chemoembolization
- Radioembolization
- SIRSpheres       Theraspheres
- Portal Vein Embolization

### Vascular Access

- Port Placement
- PICC Placement
- Hickman Catheter Placement

### Other

\_\_\_\_\_  
\_\_\_\_\_

**For more information on these and other Interventional Radiology Procedures, please visit us  
at [www.charlotteradiology.com](http://www.charlotteradiology.com)**