



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**