Interventional Radiology Referral Form

UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

IR REFERRAL PHONE: 206-598-6209
IR REFERRAL FAX: 206-598-3581

☐ UW Medical Center - Montlake
1959 NE Pacific Street, Seattle, WA 98195

☐ UW Medical Center - Northwest
1550 N 115th St, Seattle, WA 98133

Last Name: _____ First Name: _____ Date of Birth: _____

Phone: _____ Gender: M F ☐ Interpreter/Language: _____

Insurance Carrier: _____ Insurance ID#: _____

EXAM INFORMATION

PROCEDURE REQUESTED:

(Please indicate if exam is considered "clinically urgent")

HISTORY/REASON FOR EXAM:

PLEASE ATTACH RELEVANT CLINICAL NOTES

Prior Related Imaging Type: _____ Facility: _____ Date: _____

Provider Signature (required)	**Provider Name (please print)**	**Phone**	**Date**
(Provider signature required. Do not use rubber stamp)			

Provider NPI #: _____ **Location:** _____
(If first time referral)