Interventional Radiology Clinic
4722 Quail Lakes Dr.
Stockton, CA 95207
Phone: (800) 604-7240
Fax: (209) 249-5375

Interventional Radiology Referral Request Form

Referring Physician Information:

From: _____MD Phone: ( )_____

Address: _____ City: _____ Fax: ( )_____

Specialty: _____ PCP: _____

Phone: ( )_____ Fax: ( )_____

*MD Signature: _____ Date: _____

*Required Patient Information:

*Last Name: _____ *First Name: _____ MI: __

*DOB: _____ *Gender: _____ *Sex Assigned at Birth_____

*Patient's Phone: ( )_____ *Patient's Address: _____

*City/State/Zip: _____ *Needs Interpreter? ____ Language: _____

*Parent or Caregiver: _____ *Phone: ( )_____

*Diagnosis: _____ *ICD-10 Code: _____

Reason for Referral: *Please attach supporting medical records and proof of insurance.* Number of pages attached _____ *By providing the information requested and signing above, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.*

_____

_____

_____

*Insurance Plan: _____ Medical Group: _____

*Requires Authorization? Y____ N____ *Auth # _____

*CPT Code Approved: _____ *# of Visits Authorized_____
*Auth Expiration Date_____