

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 signature required. Do not use rubber stamp)

Provider Name (please print)

Phone

Date

Provider NPI #: _____
(If first time referral)

Location: _____