



Interventional Radiology

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax #:
Clinical History:		
Is the patient diabetic?	Yes No	If yes, list medications:
Is the patient pregnant?	Yes No	
Physician Signature:		Date:

Interventional Radiology

- Hysterosalpingogram
- Venous Doppler
- Consultation for varicose vein treatment
- Consultation for uterine fibroid embolization
- Thyroid Biopsy
- Therapeutic Joint Injection (Please Specify Joint): _____
- Arthrogram
- Other (Please Specify): _____

Hours of Operation: Monday – Friday 8am – 4pm, Sunday 9am-4pm

Please call 212.590.5527 to schedule an appointment.

Appointment Date / Time: _____

Pre-Auth#: _____

Please have your insurance card available.
Please Note: Co-payments are collected at time of visit.