# Patient Referral Form

## Interventional Radiology Center

1226 East Water Street
Syracuse NY 13210

**Send referrals to:**
Email: AMP@IRCenters.com
Fax or Call: (315) 478-4185

**Date:** _____ **Physician Requesting:** _____

| | | | |
|---|---|---|---|
| Patient's Name: | | | |
| | First | Last | Middle Initial |
| Patient's Address: | | | |
| | Street | | |
| | | | |
| | City | ST | ZIP |
| Date of Birth: | | | |
| SS# | | | |
| Home Phone Number: | | | |
| Mobile Phone Number: | | | |

**Reason for referral to the Interventional Radiology Center**

**Urology:**

- ☐ Prostate Artery Embolization for BPH
- ☐ Vericocele Embolization

**Gastrointestinal**

- ☐ Hemorrhoid Embolization

**Gynecology**

- ☐ Uterine Fibroid Embolization
- ☐ Ovarian vein embolization for the treatment of pelvic congestion syndrome

**Ortho / Pain / Neuro**

- Genicular Artery Embolization | ___ Osteoarthritis Pain ____ Hemarthrosis

**Comments:** _____

_____

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Some or all of the following may be required to be faxed to our office:
1. Insurance cards 2. Patient's Demographic Sheet 3. Medications 4. Most Recent H&P