

Tel (415) 353-1300
Fax: (415) 353-8570
Monday-Friday, 7:30 a.m.-5:00 p.m.
<https://radiology.ucsf.edu/patient-care/sections/ir>

Referral Form

Thank you for choosing to refer your patient to us. To start the referral process, please fax this completed form to the body Interventional Radiology at **415-353-8570** along with:

Patient Information

Name of patient _____
DOB: _____ Interpreter needed: Yes No Language: _____
Hm ph: _____ Wk ph: _____ Cell ph: _____
If child, name of parent: _____
Address: _____
City: _____ Zip: _____
Insurance: Include patient's insurance card (both sides) and HMO authorization if required

Consultation Request Information

Diagnosis/ICD-10: _____
Reason for referral: _____

Referring Physician Information

Referring MD: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____
PCP name: _____ Phone: _____ Fax: _____

PHYSICIAN'S SIGNATURE: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.