UCSF Health

REFERRAL FORM

UCSF Medical Center – Neuroendovascular Surgery
505 Parnassus Ave, Room L308
San Francisco, CA 94143-0628

Phone (415) 353-1863
Fax (415) 353-8606
https://radiology.ucsf.edu/neuroendovascular-surgery

Steven Hetts, M.D.
Adib Abla, M.D.
Matthew Amans, M.D.
Daniel Cooke, M.D.
Randall Higashida, M.D.
Kazim Narsinh, M.D.
Luis Savastano, M.D.
Christopher Dowd, M.D. (Emeritus)
Elicia Fox Chaney, N.P.
Shaadi Settecase, N.P.
Marlena Burt, N.P.
Stacy Wong, N.P.

Thank you for choosing to refer your patient to us. To start the referral process, please fax this completed form to **415-353-8606** along with:

*** Brief pertinent medical records, including test results that support the consultation**
*** Send all Radiological images (ie angiogram, MRI/MRA, CT, CTA etc in DICOM format) electronically via Lifeimage/Powershare/Ambra or if these services are unavailable, send CDs to the address listed above.**

Any missing items may delay the referral review process.

PATIENT INFORMATION

Name of patient____
DOB: ____________________ **Interpreter needed: Yes No Language:** ________________
Hm ph: ____________________ **Cell ph:** _________________ **(Indicate the primary number)**
If child, name of parent:____
Address:____
City/State: ____ **Zip:** ________________
Insurance: Include patient's insurance card (both sides) & HMO authorization if required

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-10: (check all that apply)

- o Brain aneurysm
- o Brain arteriovenous malformation (AVM)
- o Brain tumor
- o Head/neck tumor
- o Vascular malformation
- o Carotid artery disease & stenosis
- o Chronic subdural hemorrhage
- o Cushing's syndrome
- o Dissection of carotid/vertebral arteries
- o Dural arteriovenous fistula (DAVF)
- o Idiopathic intracranial hypertension
- o Intracranial atherosclerosis
- o Retinoblastoma
- o Spinal AVM or DAVF
- o Stroke – acute ischemic or hemorrhagic
- o Other__________________
  ____
  ____
  ____

Reason for referral: ____

By providing the information requested and signing below, 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.

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.