STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center
INTERVENTIONAL RADIOLOGY

Stanford Interventional Radiology
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Website: www.ir.stanfordhospital.com

New Patient Intake/ Self-Referral Form

Please complete and return to initiate the scheduling process. Thank you!

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Work Phone: _____

Date of Birth: _____ Age: _____ Email:_____

Emergency Contact/Caregiver: _____ Contact Number: _____

Relationship to Patient: _____

A few medical questions so we can determine how best to help you.

Why would you like to be seen by Interventional Radiology? _____

_____

Symptoms: _____

_____

Previous Treatments and by Whom:_____

_____

Recent Imaging, Type and Date: _____

How did you hear about us? _____

Who should we keep in contact with regarding your care at Stanford?

Referring Provider: _____ Specialty: _____ Phone: _____
(If none, please check here ☐)
Facility: _____ Address: _____ Fax: _____

Primary Care Provider: _____ Phone: _____ Fax: _____
(If none, please check here ☐)
Facility: _____ Address: _____

Other Provider: _____ Phone: _____ Fax: _____
(Optional)
Facility:_____ Address: _____

Insurance Information:

Insurance Company Name: _____ Type of Policy (i.e. HMO, PPO, etc.)_____

Subscriber ID #: _____ Group #_____

Subscriber Name: _____Date of Birth_____Relation to Patient: _____

Member Cust. Svc. Phone #:_____Provider (pre-cert.) Phone #:_____