STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center
INTERVENTIONAL RADIOLOGY

Stanford Interventional Radiology
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DVT Clinic New Patient Intake/ Self-Referral Form

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Work Phone: _____

Date of Birth: _____ Age: _____ Email: _____

When did your DVT symptoms begin? _____ **When was your DVT diagnosed?** _____

What were those symptoms and have they changed? _____

_____

What type of imaging have you had? _____ **When?** _____

Were you started on blood thinners? When? _____

Have you been diagnosed with a blood clotting disorder? _____

What other treatments have been attempted? _____

_____

Other history you feel we should know _____

_____

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 (please fax us a copy of your card too):

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 #: _____