

Legacy Salmon Creek Medical Center

INTERVENTIONAL RADIOLOGY REFERRAL FORM

Form Updated 6-2026. Please use this referral form for Radia IR referrals.

2211 NE 136th Street
Vancouver, WA 98686
Phone: (360) 487-1800 Fax: (360) 487-1889

Reason for Referral: (Check boxes)

CPT Code for Procedure Requested: _____ **ICD 10 code:** _____

- | | |
|--|---|
| <input type="checkbox"/> Port Placement | <input type="checkbox"/> Abscess Drain |
| <input type="checkbox"/> Dialysis Cath Placement | <input type="checkbox"/> Pleural Catheter Placement |
| <input type="checkbox"/> Central Line Placement | <input type="checkbox"/> Peritoneal Catheter Placement |
| <input type="checkbox"/> G/J Tube Placement | <input type="checkbox"/> Transjugular intrahepatic portosystemic shunt (TIPS) |
| <input type="checkbox"/> IVC Filter Placement | <input type="checkbox"/> Uterine Fibroids/Uterine Artery Embolizatic |
| <input type="checkbox"/> Nephrostomy Tube/Ureteral Stent | <input type="checkbox"/> Biopsy: _____ |
| <input type="checkbox"/> Biliary/Chole Drain | _____ |
| <input type="checkbox"/> Removal of: _____ | <input type="checkbox"/> Other: _____ |
| _____ | _____ |

*****Send with an order form for labs/pathology -or- bone marrow pathology order form*****

Referring Physician Information:

Ordering Physician: _____

Clinic Name: _____

Telephone: _____ Fax: _____

Office contact: _____ Phone: _____

Patient Information:

Name of Patient: _____

Sex: Female Male Date of Birth: _____ Best contact #: _____

Insurance: _____ Authorization Number: _____

Is the patient on blood thinners? Pradaxa Coumadin/Warfarin Aspirin Other

Has patient had previous imaging? Yes No

If yes, where? Legacy PeaceHealth Other: _____ Image Date: _____

Please fax the following information with this request to 360-487-1889:

Demographics Copy of Insurance Card Diagnostic imaging History and Physical Medication List



