



# Patient Referral Form

## Interventional Radiology Center

350 W. Wilson Bridge Road  
Worthington, OH 43085

**Send referrals to:**  
Email: [COUG@IRCenters.com](mailto:COUG@IRCenters.com)  
Fax or Call: (614) 318-4078

**Date:** \_\_\_\_\_ **Physician Requesting:** \_\_\_\_\_

Patient's Name:			
First	Last	Middle Initial	
Patient's Address:			
Street			
City	ST	ZIP	
Date of Birth:			
SS#			
Home Phone Number:			
Mobile Phone Number:			

### Reason for referral to the Interventional Radiology Center

#### Urology:

- Prostate Artery Embolization for BPH
- Varicocele Embolization

#### Gastrointestinal

- Hemorrhoid Embolization

#### Gynecology

- Uterine Fibroid Embolization
- Ovarian vein embolization for the treatment of pelvic congestion syndrome

#### Ortho / Pain / Neuro

- Genicular Artery Embolization | \_\_\_ Osteoarthritis Pain \_\_\_ Hemarthrosis

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Some or all of the following may be required to be faxed to our office:

1. Insurance cards
2. Patient's Demographic Sheet
3. Medications
4. Most Recent H&P