PALO ALTO INTERVENTIONAL

Physician Referral

to Fabio Komlos, MD · Vascular & Interventional Radiology

FAX THIS FORM TO	QUESTIONS? PHYSICIAN LINE
650-404-8447	**650-404-8446**

1 PATIENT

Patient name _____ Date of birth _____ Phone _____

2 REASON FOR REFERRAL

- ☐ **Peripheral vascular disease** — Claudication, critical limb ischemia, non-healing wounds
- ☐ **Interventional oncology** — Biopsy, ablation, Y-90, chemoembolization
- ☐ **Varicose veins** — Venous insufficiency, symptomatic veins
- ☐ **Prostate artery embolization** — Enlarged prostate (BPH), lower urinary tract symptoms
- ☐ **Genicular artery embolization or ablation** — Knee osteoarthritis pain
- ☐ **Interventional pain treatment** — Injections, nerve ablation, vertebral augmentation
- ☐ **Other** _____

3 CLINICAL NOTES

Diagnosis / question for IR

_____

_____

_____

Urgency ☐ Routine ☐ Urgent

Please attach recent notes, relevant imaging reports and labs, and the patient's blood thinners if any.

4 REFERRING PHYSICIAN

Name _____ Practice / clinic _____

Phone _____ Fax _____

Signature _____ Date _____

For your patient

Procedure guides, videos and what to expect before the visit.

paloaltointerventional.com

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