UCSF Health

REFERRAL FORM

UCSF Medical Center – Neuroendovascular Surgery
505 Parnassus Ave, Room L308
San Francisco, CA 94143-0628

Phone (415) 353-1863
Fax (415) 353-8606
https://radiology.ucsf.edu/neuroendovascular-surgery

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Matthew Amans, M.D.	**Ethan Winkler, M.D.**	**Marlena Burt, N.P.**
Daniel Cooke, M.D.	**Christopher Dowd, M.D. (Emeritus)**	**Stacy Wong, N.P.**
Randall Higashida, M.D.	**Van Halbach, M.D. (Emeritus)**	

Thank you for choosing to refer your patient to us. To start the referral process, please fax this completed form to **415-353-8606** along with:

> * **Brief pertinent medical records, including test results that support the consultation**
> * **Send <u>all</u> Radiological images (ie angiogram, MRI/MRA, CT, CTA etc in <u>DICOM</u> format) electronically via Lifeimage/Powershare/Ambra or if these services are unavailable, send CDs to the address listed above.**

Any missing items may delay the referral review process.

PATIENT INFORMATION

Name of patient_____ **DOB:** _____**Interpreter needed: Yes No Language:** _____ **Hm ph:** _____**Cell ph:** _____**(Indicate the primary number) If child, name of parent:**_____

Address:_____

City/State: _____ **Zip:** _____

Insurance: Include patient's insurance card (both sides) & prior authorization if required

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-10: (check all that apply)

- o Brain aneurysm
- o Brain arteriovenous malformation (AVM)
- o Brain tumor
- o Head/neck tumor
- o Vascular malformation
- o Carotid artery disease & stenosis
- o Chronic subdural hemorrhage

- o Cushing's syndrome
- o Dissection of carotid/vertebral arteries
- o Dural arteriovenous fistula (DAVF)
- o Idiopathic intracranial hypertension
- o Intracranial atherosclerosis
- o Retinoblastoma

- o Spinal AVM or DAVF
- o Stroke – acute ischemic or hemorrhagic
- o Other_____
  _____
  _____
  _____

Reason for referral: _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD: _____ **Specialty:**_____

Address:_____

Phone: _____ **Fax:**_____

PCP name: _____

Phone: _____ **Fax:**_____

PHYSICIAN'S SIGNATURE:_____