A logo for a medical company

Description automatically generated

748 Old Norcross Rd, Ste 150

Lawrenceville GA 30046

Off: (470) 509 4200

Fax: (470) 509 4201

Udaya Chintalapudi, MD

Interventional Radiology

[www.drcvascular.com](http://www.drcvascular.com)

Email: info@drcvascular.com

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_ **CHEST PORT Referral Form**

**Patient** Name: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Referring Phys. Name: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Contact Phone Number: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Referring Phys. Phone: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Date of Birth: \_ \_ \_ \_ \_ \_ \_ \_ \_ Referring Phys. Fax: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Requesting for (date): \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Patient’s Address: \_ \_ \_\_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Most Recent Lab Values: **PT** \_\_\_\_\_ (Date:\_\_\_\_\_\_\_\_\_\_\_\_\_)

**PTT**: \_\_\_\_\_\_\_ (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_)

**INR**: \_\_\_\_\_\_\_ (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ )

**Platelets**: \_\_\_\_\_\_\_\_\_\_\_ (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Is the patient on Blood Thinners: Yes / No. If yes, what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nursing Home/Hospice Patient: Yes / No. Facility Name: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Facility Phone: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Procedure** Requested: Port **PLACEMENT** / **REMOVAL**

**Clinical Diagnosis:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **ICD 10**: \_ \_ \_ \_ \_ \_ \_ \_ \_

**Type** malignancy: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **ICD 10**: \_ \_ \_ \_ \_ \_ \_ \_ \_

**Location** of malignancy: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **ICD 10**:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_

(Preferred) **Location** of Port : Right Chest / Left Chest / Right Arm / Left Arm

**X-ray Contrast Allergy:** YES / NO Allergy Premedication Given: YES / NO

This form is completed by (Signature) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_