Stanford Interventional Radiology
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IVC Clinic Director - Dr. William Kuo

IVC Filter Clinic New Patient Intake/ Self-Referral Form

Name: ______________________________ Home Phone: ____________________

Address: ______________________________ Cell Phone: ____________________

______________________________ Work Phone: ____________________

Date of Birth: ________________ Age: ______________ Email: ________________________

When was your filter placed? ______________ **Where?** ______________________________

What type of filter do you have? ____________ **Why was your filter placed?** ______________________

____

Do you have pain or other symptoms/concerns related to your filter? ______________________________

____

Have any doctors tried to remove your filter? Where? ______________________________

Do you currently have a blood clot? ______________________________

Are you on blood thinner medication(s)? ______________________________

Do you have a blood clotting disorder? ______________________________

When was your most recent ultrasound, CT, X-Ray, or MRI? Where? ______________________________

____

Who should we keep in contact with regarding your care at Stanford?

Referring Provider: ______________________ Specialty: ______________ Phone: ____________
(If none, please check here ☐**)**
Facility: ______________ Address: ______________________ Fax: ____________

Primary Care Provider: ______________________ Phone: ______________ Fax: ____________
(If none, please check here ☐**)**
Facility: ______________ Address: ______________________________

Other Provider: ______________________ Phone: ______________ Fax: ____________
(Optional)
Facility:______________ Address: ______________________________

Insurance Information (please fax us a copy of your card too):

Insurance Company Name: ______________________ Type of Policy (i.e. HMO, PPO, etc.)________

Subscriber ID #: ______________________ Group #______________________

Subscriber Name: ______________Date of Birth__________Relation to Patient: ____________

Member Cust. Svc. Phone #:______________Provider (pre-cert.) Phone #:______________