



**For Scheduling:**

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_ Insurance: \_\_\_\_\_

PRIOR IMAGING:  CT  US  MRI  NUC MED  PET  X-RAY DATE: \_\_\_\_\_

Images on: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_ | Blood Thinner:  Y  N | If yes, blood thinner name: \_\_\_\_\_

**Embolization**

- Adhesive Capsulitis Embolization (ACE) (Frozen Shoulder)
- Elbow Artery Embolization (EAE)
- Genicular Artery Embolization for Knee OA (GAE)
- Hemorrhoid Artery Embolization (HAE)
- Iliac Vein Stenosis/May-Thurner Syndrome
- Pelvic Congestion
- Peripheral Arterial Disease (PAD)
- Plantar Fasciitis Embolization

- Prostate Artery Embolization (PAE)
- Uterine Fibroid Embolization (UFE or UAE)
- Varicocele Embolization
- Varicose Vein Treatment
- Vertebral Augmentation
- Other: \_\_\_\_\_

**Interventional Oncology**

- Tumor Therapy Consult (tumor ablation, Y90, etc)

Notes:

Referring provider (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_