Dotter Interventional Radiology:

IVC Filter Clinic Patient Questionnaire

Name________________________Date of Birth________________________

When and where was IVC filter placement?
Facility ________________________________Date _________________
City __________________________State __________

Physician who placed IVC filter? ________________________________

Has someone tried to remove the IVC filter? Circle correct response.  
(Yes)  (No)
If so, when and where?
Facility ________________________________Date _________________
City __________________________State __________

Physician who attempted IVC filter removal? ________________________________

Primary Care Physician:
Name________________________Phone________________________
Facility ________________________________

Please bring:

- This completed form
- List of all current medications and supplements
- List of any questions
- Family member or friend for support and transportation

To schedule an appointment, call or email: (503)-494-7117
ivcfilter@ohsu.edu
Fax: (503) 494-7664
Location: Physician’s Pavilion 2nd floor Room 220