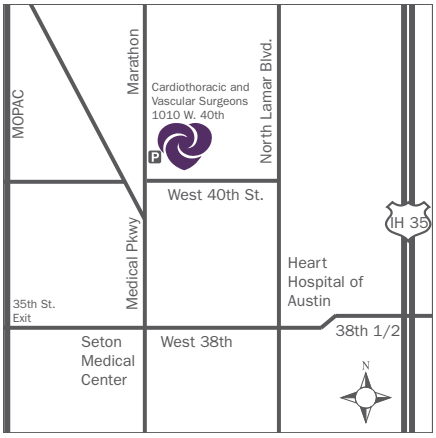
Cardiothoracic and Vascular Surgeons

Service Requisition Form

1010 West 40th Street, Austin, TX 78756
ph 512.459.8753 **fax 512.459.0586** www.ctvstexas.com



Referring Physician: _____

Phone (_____) _____ Fax (_____) _____

Patient Name: _____

Phone (_____) _____ Date of Birth: _____

SSN: _____ - _____ - _____ **MD Signature Required:** _____

☐ **Referral for Office Consultation with one of our Cardiothoracic Surgeons**

☐ John D. Oswalt, M.D. ☐ Mark C. Felger, M.D. ☐ Faraz Kerendi, M.D. ☐ Brannon R. Hyde, M.D.
☐ Stephen J. Dewan, M.D. ☐ William F. Kessler, M.D. ☐ Eric M. Hoenicke, M.D. ☐ First Available
☐ Michael C. Mueller, M.D. ☐ Hunter Q. Kirkland, M.D. ☐ Brian Lima, M.D.

☐ **Cardiac** ☐ **Thoracic/Pulmonary**

Reason for Referral: _____

Please indicate Consult ***or*** Vascular Studies:

☐ **Referral for Office Consultation with one of our Board-Certified Vascular Specialists.**

☐ Phillip J. Church, M.D. ☐ Jeffrey S. Jobe, M.D. ☐ Scott A. Seidel, M.D. ☐ First Available
☐ Mark T. Stewart, M.D. ☐ Stephen M. Settle, M.D. ☐ Jeffrey M. Apple, M.D.
☐ John K. Politz, M.D. ☐ Joe K. Wells III, M.D. ☐ Mazin I. Foteh, M.D.

Reason for Referral:

☐ Carotid Stenosis ☐ Abnormal Carotid Ultrasound ☐ Aortic or Other Aneurysm
☐ Peripheral Vascular Disease ☐ Claudication/Leg Ischemia ☐ Spine Exposure
☐ Renal Artery Stenosis ☐ Establish or Evaluate Dialysis Access ☐ Mesenteric Ischemia
☐ Venous Disease ☐ Other _____

☐ **Request for Vascular Studies** Vascular Lab Accredited by ACR

**This form is intended to facilitate the care of your patients with vascular needs. If a non-invasive vascular study is all that is required, it will be read by the first available physician to expedite the results.*

Clinical Diagnosis _____

Arterial	☐ Carotid Ultrasound	☐ Aortic Aneurysm Ultrasound	
	☐ Lower Extremity Arterial Duplex	☐ Ankle-Brachial Indices (ABI)	☐ Other_____
Venous/other	☐ Upper Extremity	☐ Dialysis Access Evaluation	
	☐ Lower Extremity	☐ Other_____	

☐ Request for Computed Tomography Studies

CT Angiography *Includes Contrast*

☐ Head
☐ Neck
☐ Chest
☐ Pelvis
☐ Upper Ext
☐ Lower Ext
☐ Abdomen
☐ Abd Aorta + Run Off
☐ Bilat Run Off Lower

CT Head ☐
☐ Without
☐ With
☐ Without/With

CT Chest ☐
☐ Without
☐ With
☐ Without/With

CT Orbit/Fossa/Ear ☐
☐ Without
☐ With
☐ Without/With

CT Abdomen ☐
☐ Without
☐ With
☐ Without/With

CT Facial ☐
☐ Without
☐ With
☐ Without/With

CT Pelvis ☐
☐ Without
☐ With
☐ Without/With

CT Soft Tissue Neck ☐
☐ Without
☐ With
☐ Without/With

CT Extremity ☐

Upper
☐ Without
☐ With
☐ Without/With

Lower
☐ Without
☐ With
☐ Without/With

Specify Extremity: _____

Specify Right or Left: _____

✓ Provide CREATININE results within past 60 days if available

When Completed, Please Fax to 512.459.0586