



Vascular Services Referral

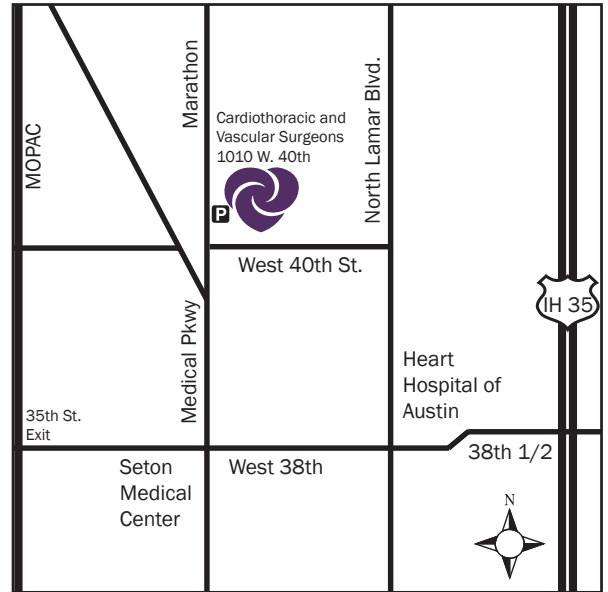
Referring Physician:

Phone (_____) _____ Fax (_____) _____

Patient Name:

Phone (_____) _____ Date of Birth: _____

SSN: _____ - _____ - _____



Please indicate Consult **or** Vascular Studies:

Referral for Office Consultation with One of Our Board-Certified Vascular Specialists

- Phillip J. Church, MD, FACS
- Mark T. Stewart, MD, FACS
- John K. Politz, MD, FACS
- Jeffrey S. Jobe, MD, FACS
- Stephen M. Settle, MD, FACS
- Joe K. Wells, MD, FACS
- Scott A. Seidel, MD, FACS
- Jeffrey M. Apple, MD, FACS

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
 - Abdominal Aortic Aneurysm Ultrasound
 - Lower Extremity Arterial Doppler
 - Other _____

- Venous/Other**
- Upper Extremity
 - Lower Extremity
 - Dialysis Access Evaluation
 - Other _____

Request for Computed Tomography Studies

CT Angiography Includes Contrast

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> CT Head <input type="checkbox"/> | <input type="checkbox"/> CT Orbit/Fossa/Ear <input type="checkbox"/> | <input type="checkbox"/> CT Facial <input type="checkbox"/> | <input type="checkbox"/> CT Soft Tissue Neck <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Without | <input type="checkbox"/> Without | <input type="checkbox"/> Without | <input type="checkbox"/> Without |
| <input type="checkbox"/> Chest | <input type="checkbox"/> With | <input type="checkbox"/> With | <input type="checkbox"/> With | <input type="checkbox"/> With |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Without/With | <input type="checkbox"/> Without/With | <input type="checkbox"/> Without/With | <input type="checkbox"/> Without/With |
| <input type="checkbox"/> Upper Ext | | | | |
| <input type="checkbox"/> Lower Ext | <input type="checkbox"/> CT Chest <input type="checkbox"/> | <input type="checkbox"/> CT Abdomen <input type="checkbox"/> | <input type="checkbox"/> CT Pelvis <input type="checkbox"/> | <input type="checkbox"/> CT Extremity <input type="checkbox"/> |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Without | <input type="checkbox"/> Without | <input type="checkbox"/> Without | <i>Upper</i> |
| <input type="checkbox"/> Abd Aorta + Run Off | <input type="checkbox"/> With | <input type="checkbox"/> With | <input type="checkbox"/> With | <input type="checkbox"/> Without |
| <input type="checkbox"/> Bilat Run Off Lower | <input type="checkbox"/> Without/With | <input type="checkbox"/> Without/With | <input type="checkbox"/> Without/With | <i>Lower</i> |
| | | | | <input type="checkbox"/> Without |
| | | | | <input type="checkbox"/> With |
| | | | | <input type="checkbox"/> Without/With |

✓ Provide CREAT results within past 60 days if available

Specify Extremity: _____
Specify Right or Left: _____

When Completed, Please Fax to 512.459.0586