



Vascular Services Referral

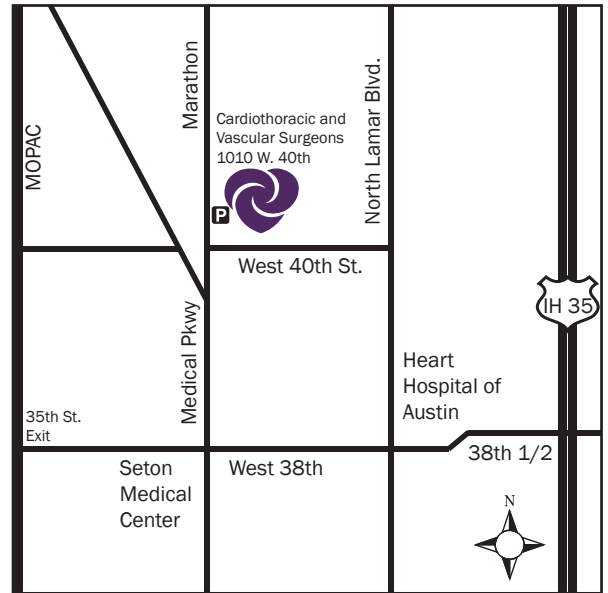
Referring Physician:

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
First Available

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

- Head, Neck, Chest, Pelvis, Upper Ext, Lower Ext, Abdomen, Abd Aorta + Run Off, Bilat Run Off Lower
CT Head, CT Chest, CT Orbit/Fossa/Ear, CT Abdomen, CT Facial, CT Pelvis, CT Soft Tissue Neck, CT Extremity

Provide CREAT results within past 60 days if available

Specify Extremity:
Specify Right or Left:

When Completed, Please Fax to 512.459.0586