HILL | VASCULAR & VEIN CENTER

VASCULAR TESTING/SURGERY REFERRAL FORM

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ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

PATIENT INFORMATION:

Date _____

Patient Name _____ DOB _____
First Middle Last

Patient Phone _____ Email _____ Insurance _____

PHYSICIAN INFORMATION:

Ref. Physician Name _____ Phone _____ Fax _____

Ref. Practice Address _____

DIAGNOSIS & COMMENTS:

RELATED STUDIES:

If yes, please indicate the following:

Study Type: _____ Location: _____ Date _____
Study Type: _____ Location: _____ Date _____

PATIENT HISTORY, check all that apply:

Family History of AAA/TAA ☐ High Cholesterol ☐ Prior CABG ☐
History of Vascular Disease, MI, Stroke ☐ High Blood Pressure ☐ Diabetic ☐
Smoking ☐ Artheroscloerosis ☐ Other ☐
Please Specify _____

PLEASE SCHEDULE VASCULAR STUDY FOR:

ABI/TBI ☐
Carotid Artery Ultrasound ☐
Arterial Ultrasound UPPER LOWER
RIGHT LEFT BILATERAL
Venous Ultrasound UPPER LOWER
RIGHT LEFT BILATERAL
DVT Rule Out UPPER LOWER
RIGHT LEFT BILATERAL
Renal/Mesenteric Ultrasound ☐
Other ☐
Please specify: _____

PLEASE SCHEDULE CONSULT FOR:

☐ Aneurysm (abdominal aortic, thoracic, peripheral)
☐ Carotid Artery Disease (CIA, syncope, stroke)
☐ Peripheral Arterial Disease (claudication, resting pain, wounds)
☐ Venous Insufficiency (varicose veins, leg swelling)
☐ Deep Vein Thrombosis (DVT)
☐ Dialysis Access
☐ Wound Care
☐ **NO CONSULT; VASCULAR LAB REPORT ONLY**

Referring Physician Signature: **Date:**

We thank you for entrusting your patients to Hill Vascular & Vein Center.

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