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 _____

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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 ☐

Venous Ultrasound ☐

DVT Rule Out ☐

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

☐ Genicular Artery Embolization

☐ **NO CONSULT; VASCULAR LAB REPORT ONLY**

Referring Physician Signature: **Date:**

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