SOUND VASCULAR & VEIN

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○ STAT

VASCULAR REFERRAL

Patient Name _____ Date _____

Date of Birth _____ Referring Physician _____

Patient Phone _____ Physician Signature _____

Insurance _____ Office Fax _____

INDICATIONS

- ○ Pain
- ○ Ulcer / Non-Healing Wound
- ○ PVD
- ○ Claudication
- ○ Decreased / Absent Pulses
- ○ Suspected DVT
- ○ Swelling / Edema
- ○ Varicose Veins
- ○ Pre-Surgical Evaluation
- ○ Other _____

VASCULAR CONSULTATION

- ○ Vascular Consult
- ○ BIL ○ Left ○ Right

ULTRASOUND

- ○ Lower Extremity Arterial / ABI
- ○ Lower Extremity Venous
- ○ Suspect DVT
- ○ Abdominal Aortic Aneurysm
- ○ Cerebrovascular (Carotid)
- ○ BIL ○ Left ○ Right
- ○ Other _____

INTERVENTION

- ○ Angiogram with possible intervention
- ○ Inferior Vena Cave (IVC) Filter
- ○ Venous Port
- ○ Varicocele
- ○ Uterine Fibroid Embolization (UFE)
- ○ Pelvic Venous Congestion (PVCS)
- ○ BIL ○ Left ○ Right
- ○ New Placement ○ Removal