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Vascular & Endovascular Surgery

Date: ______________________________

I am referring ______________________________ to your office for vascular ❑ **TESTING** and/or ❑ **CONSULT**
(Name of Patient)

Patient DOB ____________________ Patient Phone # ______________________________

(Please check each test requested and all the reasons that apply for each test.)

❒ CAROTID DUPLEX ULTRASOUND
Reason:
❒ Bruit
❒ Amaurosis Fugax
❒ TIA
❒ CVA

❒ PERIPHERAL ARTERIAL EVALUATION - WITH SEGMENTAL PRESSURES AND WAVEFORMS THAT INCLUDES ABI. ❒ TBI (LOWER EXTREMITY)
Reason:
❒ Claudication
❒ Decreased Pulses
❒ Leg Ulcer
❒ Rest Pain
❒ Gangrene
❒ Digital Cyanosis (Raynaud or Buerger)

❒ EXERCISE TESTING*
*If highly suspicious of claudication, exercise is recommended

❒ PERIPHERAL ARTERIAL EVALUATION (UPPER EXTREMITY)
Reason:
❒ Subclavian Steal Syndrome
❒ Thoracic Outlet Syndrome
❒ Digital Cyanosis (Raynaud or Buerger)
❒ Claudication

❒ VENOUS DUPLEX ULTRASOUND (UPPER OR LOWER EXTREMITY)
Reason:
❒ Edema - R/O DVT
❒ Venous Insufficiency / Reflux / Varicose Veins

❒ ABDOMINAL AORTIC DUPLEX
❒ R/O AAA

❒ MESENTERIC ARTERY DUPLEX
❒ R/O Mesenteric Ischemia

❒ RENAL ARTERY DUPLEX
❒ Uncontrolled HTN / R/O Renal Artery Stenosis

OTHER
Reason: ______________________________
Comments: ______________________________
____

❒ PLEASE CALL ME WITH RESULTS
❒ PLEASE FAX ME THE RESULTS

Note: We will fax a copy of the results upon transcription to:
Name of Referring Dr./Office: ____________________
____
Telephone: ______________________________
Fax: ______________________________

Your patient has been scheduled at our office on ____________________ at ____________

Thank you for your referral. We appreciate being a part of your patient's care team!

This form will be returned to you with your patient's appointment information completed above.