Vascular Health Center
Comprehensive Vascular Care

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PATIENT ULTRASOUND REFERRAL FORM

PATIENT NAME (Last, First, Middle) _____

DATE OF BIRTH _____ SOCIAL SECURITY#_____

ADDRESS _____ CITY _____STATE _____ ZIP _____

HOME # _____ MOBILE #_____ E-MAIL _____

PREFERRED METHOD OF CONTACT (Circle One): HOME/ MOBILE / EMAIL / OTHER _

REFERRING PROVIDER NAME _____REFERRING PROVDER PHONE # _____

REFERRING PROVIDER FAX # _____PATIENT'S PRIMARY INSURANCE _____

PATIENT'S SECONDARY INSURANCE _____

PLEASE SEND A COPY OF THE PATIENT'S INSURANCE CARD(S), FRONT AND BACK.

DOES PATIENT'S INSURANCE REQUIRE AN AUTHORIZATION? YES / NO (Circle One)

DIAGNOSIS _____

CIRCLE TEST

CAROTID • ABDOMINAL AORTA • AORTA ILIAC • RENAL ARTERY • DIALYSIS ACCESS •

VASCULAR SCREENING UPPER EXTREMITY • ARTERIAL DUPLEX • LOWER EXTREMITY

ARTERIAL DUPLEX • UPPER EXTREMITY VENOUS DUPLEX • LOWER EXTREMITY VENOUS

DUPLEX • LOWER DVT STUDY (bilat /left/ right)/TOE PRESSURES – Yes / No (Circle One)

ORDERING PROVIDER'S SIGNATURE (REQUIRED) _____

REFER TO A PROVIDER AFTER ULTRASOUND YES / NO / ONLY IF ABNORMAL (Circle One)

WHICH PROVIDER? FIRST AVAILABLE / ELSHAARAWY / ALAM (Circle One)

*****PLEASE MAKE SURE TO SEND PATIENT'S MEDICAL RECORDS IF YOU ARE REQUESTING TO SEE A PROVIDER*****

FOR OFFICE USE ONLY

APPPOINTMENT DATE _____ TIME _____
APPPOINTMENT DATE _____ TIME _____
PLEASE NOTIFY PATIENT OF APPOINTMENT / PATIENT CONFIRMED / LEFT VOICEMAIL
STAFF INITIALS _____

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