VASCULAR DIAGNOSIS &
TREATMENT REFERRAL PAD
O: 989-790.2600
F: 989790.3311

Date_____

Referring Physician Name_____**Phone#**_____**Fax#**_____

Patient Name_____**Phone#**_____

Patient Date of Birth____/____/_____ **Address, State, Zip**_____

Diagnosis/Comment

Related Studies: ☐ **Yes** ☐ **No. If Yes, please indicate study type, facility location and date of study**

Study type:	Facility:	Date:

PATIENT HISTORY

Check all that apply:

☐ Family History of AAA/TAA	☐ High Cholesterol	☐ Prior CABG
☐ History of Vascular Disease, MI, or Stroke	☐ High Blood Pressure	☐ Diabetic
☐ History of or Currently Smoking	☐ Atherosclerosis	☐ Other_____

PATIENT SYMPTOMS

Check all that apply:

☐ Abdominal pain	☐ Claudication (R/L)	☐ Leg or Heel Pain (R/L)
☐ Tender, Pulsating Abdominal Mass	☐ Skin Discoloration (R/L)	☐ Ulcers or Blisters
☐ GI Symptoms	☐ Numbness in Feet, Toes or Legs	☐ Lower Extremity Pain
☐ TIA/Stroke	☐ Varicose Veins	☐ Lower Extremity Swelling

CONSULT and EVALUATION

Please Schedule Consult for:	**Please Schedule Vascular Study for:**
☐ Aneurysm (abdominal aortic, thoracic, peripheral)	☐ Ultrasound
☐ Carotid Artery Disease (CIA, syncope, stroke)	☐ Carotid Duplex/Doppler
☐ Peripheral Arterial Disease (claudication, resting pain, wounds)	☐ Lower/Upper Extremity Arterial Duplex/Doppler
☐ Deep Vein Thrombosis (DVT)	☐ Lower/Upper Extremity Venous Duplex/Doppler
☐ Dialysis Access	☐ Renal/Mesenteric Duplex
☐ Wound Care	☐ Other

Appointment Date:_____Time:_____Physicain:_____Location:_____

Office Scheduler:_____Date:_____