SOUTHERN KENTUCKY VASCULAR

VASCULAR REFERRAL BY PHYSICIAN TO:

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When does patient need to be seen? *(Check one)*:

- ☐ ASAP
- ☐ First Available

***SCHEDULED DATE AND TIME** *(To be completed by SKV)*:*

Patient Name: _____ **Date of Birth:** _____

Address: _____

Home phone: _____ Work:_____ Cell: _____

Insurance: _____

(Please send copy of Insurance card)

Referring physician:_____

Contact Person: _____ TItle: _____

Contact phone: _____ Clinic phone :_____ Ext: _____

Reason for Visit:

(Select reason below)

	Peripheral Arterial Disease		**Swelling, Lower Extremity**
	AAA		**Swelling, Upper Extremity**
	Carotid Artery Stenosis		**Fistula Creation**
	Venous Insufficiency		**Varicose Veins**
	DVT/PE		**Non-Healing Wounds**
	Mesenteric Stenosis		**Other:**
	Renal Stenosis		

Notes & Studies to send with Vascular Referral: *(Including these items would be extremely helpful.)*

- ☐ **Referring note**
- ☐ **Updated Medication List**
- ☐ **Copy of insurance cards**
- ☐ **CT or MRIs related to the appointment** *(abdomen, pelvis, with or without runoff)* **within the last year**
- ☐ **CTA or MRA of neck – within the last year**
- ☐ **ABI** *(Ankle Brachial Index)* **- within the last 6 months**
- ☐ **Angiogram** (post-op reports- renal, peripheral, carotid) **– within the last year**
- ☐ **Ultrasounds or Doppler Studies - carotid artery, arterial duplex of any extremities, abdominal, venous** *(for DVT or insufficiency studies)* **- within the last 6 months**