vascular center

Minimally Invasive Medicine Specialists

# REFERRRAL FORM PVD TREATMENT

## Fax to: (909) 391-9101

***Please include: Face Sheet, Insurance Cards, H&P, and Medication List***

**Today's Date** ____________________ **Status:** ☐ Stat ☐ Urgent ☐ Standard

**Patient Name:** ____________________ **DOB** ____________________

**Phone #** ____________________ **Primary Insurance** ____________________

**Referring Physician** ____________________

**Phone #** ____________________ **Fax** ____________________

**PROCEDURE:**

☐ Renal Angiogram ☐ Arterial Doppler ☐ EVLT ☐ Lower Extremity Arteriogram

☐ Venous Doppler ☐ Other ____________________

**INDICATIONS**

☐ Pain ☐ Swelling ☐ Drainage ☐ Ulceration ☐ Discoloration ☐ Open Sore

☐ Gangrene ☐ Other ____________________

**ALLERGIES (Including contrast allergies):**

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|---|
| |

**BLOOD THINNERS:** ☐ Coumadin ☐ Aspirin ☐ Plavix

**DIABETIC:** ☐ No ☐ Yes – Insulin Type ____________________

**Emergency Contact:** ____________________ **Phone #** ____________________

**Transportation** ____________________

**DPM/MD Signature** ____________________ **Date** ____________________

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