



680 Buckles Court North, Suite 2C
Gahanna, OH 43230
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www.vivevascular.com

Date: _____ How urgently does this referral need scheduled: Critical 2-3 Weeks Non-Urgent

Referring Provider: _____ Phone: _____ Fax: _____

Primary Provider: _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

SSN: _____ Patient Phone: _____ Alternate Phone: _____

Patient Address: _____

Primary Insurance: _____ ID No: _____ Group No: _____

Secondary Insurance: _____ ID No: _____ Group No: _____

Reason for consultation or procedure requested:

Please Schedule Consult for:

- Deep Vein Thrombosis (DVT)
- Peripheral Arterial Disease (PAD)
- Varicose Veins / Chronic Venous Insufficiency
- Carotid Artery Disease
- Aneurysm (abdominal aortic, thoracic, peripheral)
- Mesenteric/Renal Artery Atherosclerosis
- Dialysis Access

Select any requested vascular testing:

- Venous Duplex to assess for DVT
- Arterial Duplex & ABI
- Venous Duplex to assess for venous reflux
- Carotid Artery Duplex
- Abdominal Aorta Duplex
- Mesenteric or Renal Artery Duplex
- Access Duplex or Vein Mapping (see section below)

****PLEASE SEND CURRENT MEDICATIONS AND MOST RECENT LABS****

This section is for dialysis access consults

Reason for consult: _____

Type of existing access: _____ Dialysis Unit location: _____ Days & time: _____

Unit phone: _____ Nursing facility phone if applicable: _____

Appointment Date: _____

Thank you for referring your patient to Vive Vascular.