vive
VASCULAR

680 Buckles Ct. N, Ste 2C
Gahanna, OH 43230
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www.vivevascular.com

Date: How urgently does this referral need scheduled: ○ Critical ○ 2-3 Weeks ○ Non-Ur-

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)
- ○ Embolization (genicular, prostate, fibroid, etc.)
- ○ 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.