Institute for Vascular Testing
Referral

Patient Name: _____ DOB :_____ Phone: _____

Referring Physician Name: _____ Date: _____

Physician Phone: _____ Fax:_____ Email:_____

CEREBROVASCULAR TESTING:

_____ Carotid/Vertebral Duplex

ARTERIAL TESTING:

_____ (ABI) Lower Extremity Screening

_____ Lower Extremity Arterial

_____ Upper Extremity Arterial

_____ Aneurysm/Bypass Graft

ABDOMINAL VASCULAR EVALUATION:

_____ AAA/Aorto-Iliac

_____ Renal Artery

_____ Mesenteric

_____ IVC/Iliac Vein Screening

_____ **VENOUS THROMBOSIS/ BLOOD CLOT MANAGEMENT**
(Acute Lovenox Administration, anticoagulation instruction and management as desired by referring physician)

VENOUS TESTING:

_____ Venous Obstruction (r/o DVT)

_____ Lower Extremity R L
_____ Upper Extremity R L

_____ Reflux/Insufficiency R L

_____ Venous Mapping

_____ Lower Extremity R L
_____ Upper Extremity R L

ANCILLARY TESTING:

_____ Hemodialysis Access

_____ Radial Artery/Allen's Testing

_____ Raynaud's Testing

_____ Lower Extremity
_____ Upper Extremity

☐ **SCREENING:** (check here to include all 3)

_____ Stroke
_____ AAA
_____ PAD

INDICATIONS FOR REQUESTED TESTING: _____

_____

_____

All Vascular exams are performed by an experienced Registered Vascular Technologist and interpreted by a qualified Registered Physician Vascular Interpreter.
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