

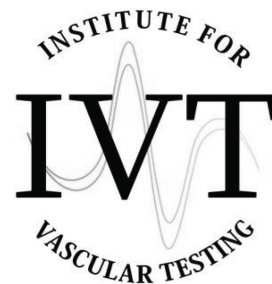
Referral

☐

Urgent

☐

Not Urgent



Please check mark for which location:

- ☐ 2255 South Bascom Avenue, Campbell CA, 95008
☐ 8420 Church Street, Gilroy CA, 95020
☐ 1667 Dominican Way, Suite 130, Santa Cruz, CA 95065

Patient Name: _____ Date: _____

Telephone: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____

Referring Physician: _____ Referring Physician Telephone/Fax: _____

ARTERIAL TESTING:

- ☐ Hemodialysis Access Surveillance
☐ Lower Extremity Arterial (Duplex + ABI Testing)
☐ Aneurysm/Bypass Graft (Surveillance)
☐ Upper Extremity Arterial Evaluation
☐ Arterial Exercise Testing

CEREBROVASCULAR TESTING:

- ☐ Carotid/Vertebral Duplex

ANCILLARY TESTING:

- ☐ Radial Artery/Allen's Testing
☐ Raynaud's Testing UE LE
☐ Temporal Artery Exam
☐ Thoracic Outlet (TOS)

☐ VENOUS THROMBOSIS/CLOT MANAGEMENT

(Acute Lovenox Administration, anticoagulation instruction and management as desired by referring physician).

VENOUS TESTING:

- ☐ Reflux/Insufficiency ☐ R ☐ L
☐ Upper Extremity R/O DVT ☐ R ☐ L
☐ Lower Extremity R/O DVT ☐ R ☐ L

ABDOMINAL VASCULAR EVALUATION:

- ☐ AAA/Aorto-Iliac U/S
☐ Renal Artery U/S
☐ Mesenteric/Visceral

SCREENING (Stroke/AAA/PAD)

(Generally NOT covered by insurance)

- ☐ Stroke/Carotid
☐ AAA
☐ PAD (ABI/TBI)

Phone: 408-376-3626 Fax: 408-871-2377

www.SouthBayVascular.com • Info@SouthbayVascular.com

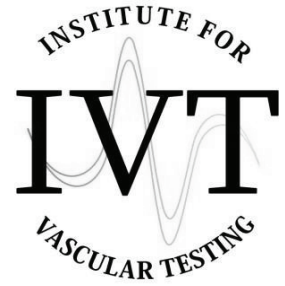
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INDICATIONS FOR REQUESTED TESTING:
