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Vascular & Interventional Radiology Services

To schedule a consultation/procedure please fax your order to **910.486.5700.** For more information please call **910.486.5950.**

Patient Name: DOB:

Patient Phone: Alternate Number:

Patient Address:

Primary Insurance: Secondary Insurance:

Referring Provider:

Contact Person:

Practice Phone: Fax:

To be completed by office staff

Appointment Date:

Appointment Time:

PLEASE ATTACH H&P AND DEMOGRAPHIC SHEET

Consultation Referral:

☐ **Arterial Intervention**
- ☐ Peripheral Artery Disease (PAD)
- ☐ Claudication
- ☐ Lower Extremity Ulcer/Wound
- ☐ Renal/Visceral Stenosis or Aneurysm
- ☐ Other___________________________

☐ **Venous Intervention**
- ☐ Deep Vein Thrombosis
- ☐ May-Thurner Syndrome
- ☐ IVC Filter Placement
- ☐ IVC Filter Removal
- ☐ Other________________________

☐ **TIPS - Cirrhosis**

☐ **Venous insufficiency**
- ☐ Swollen Ankles
- ☐ Visible Varicose Veins or Spider Veins
- ☐ Experience itching, aching, tingling, cramping, numbness and/or burning sensation in Leg(s)
- ☐ Skin Discoloration of lower Extremities
- ☐ Restless legs and/or Leg Pain while sleeping
- ☐ Tired and/or heavy sensations in Leg(s)

☐ **Gynecologic/Urologic Intervention**
- ☐ Uterine Fibroids
- ☐ Pelvic Congestion
- ☐ Varicoceles
- ☐ Enlarged Prostate/Benign Prostate Hyperplasia (BPH)
- ☐ Other________________________

☐ **Spine Intervention**
- ☐ Vertebral Compression Fractures
- ☐ Epidural Steroid Injections
- ☐ Joint Pain ☐ **R** ☐ **L**
- ☐ Other________________________

☐ **Oncology - Specify Type:**___________________
- ☐ Ablative Therapy
- ☐ Catheter Directed Therapy/Embolization

Procedure Referral:

☐ **Vascular Access**
- ☐ Port-A-Cath
- ☐ PICC

☐ **Drainage Procedures**
- ☐ Paracentesis
- ☐ Thoracentesis

☐ **Gastro/Urological**
- ☐ Gastrostomy Exchange
- ☐ Nephrostomy Placement
- ☐ Nephrostomy Exchange
- ☐ Nephrostogram

Previous Imaging:_____________________________

Diagnosis (ICD-10)_____________________________

Authorization #________________________________

Sign here

Provider Signature______________________________________ **Date:**____________________________

*****PLEASE ATTACH RECENT LABS, X-RAYS, OFFICE NOTES, MEDICATION LIST AND A COPY OF INSURANCE CARD(S)*****