



Apple Hill Vascular Associates, Ltd.
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VASCULAR LAB -- REFERRAL REQUEST FORM
****PLEASE FAX FORM TO OUR OFFICE****

Appt. Date: _____ Time: _____

Requesting Dr: _____
 Dr. Phone #: _____

Person Ordering exam: _____

Patient Name: _____ Date of Birth: _____
 Pt. Phone #: _____

Insurance: _____

Referral Needed: Yes No

TEST REQUESTED:

CEREBROVASCULAR

- Carotid Duplex
(Includes vertebral & subclavian)

ARTERIAL

- Lower²
- Lower w treadmill⁴
- Upper²
- Duplex⁵

VENOUS

- Lower³
 - RT LT
 - Bilat.
- Upper.
(Always bilateral)
- UE Mapping
(Prior to dialysis access)
- LE Mapping
(Prior to LE bypass/CABG)

VISCERAL ¹

- Aorta
- Renal
- Mesenteric
- Dialysis fistula U/S

OTHER: _____

REASON FOR STUDY: _____ ** ICD-9: _____

(*MUST INCLUDE APPROPRIATE *ICD-9 CODE* FOR REPORTING DIAGNOSES)

SPECIAL INSTRUCTIONS: _____

¹ Requires 8 hour fast (NPO); No smoking or chewing of gum the day of exam.

² Segmental pressures & Plethysmography with ABI's

³ Unilateral Venous Duplex examinations are performed unless otherwise requested.

⁴ If clinically warranted, Treadmill Exercise Testing can aid in evaluating claudication (vascular vs. neurogenic).

⁵ If clinically warranted, based on your abnormal results of Doppler study, a duplex is warranted.