



Vascular Laboratory Order Form

Referring Provider Services

All Fields are Required

Date _____ **Patient Name** _____
 Referring Provider (print) _____ MRN (if available) _____
Provider Signature _____ DOB _____
 Office phone/pager _____ Home phone _____
 Office fax _____ Work phone _____
 Clinic name _____ Address _____

Today/ASAP (if needed within 24 hours, please call (603) 650-7502 and speak to scheduler)

Indication for Study = Signs / Symptoms - (R/O will NOT be accepted)

Question to be answered _____

ICD9 Code(s) [see page 2] _____

Referral to evaluate and treat (vascular surgeon appointment)

<p>Cerebrovascular</p> <p><input type="checkbox"/> Carotid Duplex</p> <p><input type="checkbox"/> Transcranial Duplex (for vasospasm & reperfusion hyperemia only)</p> <p><input type="checkbox"/> Temporal Artery Duplex</p> <hr/> <p>Lower Extremity Arterial</p> <p><input type="checkbox"/> ABI (Ankle Brachial Index) <input type="radio"/> With Toes <input type="radio"/> Without Toes</p> <p><input type="checkbox"/> Treadmill (must have documented normal ABIs)</p> <p><input type="checkbox"/> Arterial Duplex (NOT for Claudication – select ABIs) (Typically reserved for surgical consults or possible intervention) Call (603) 650-7502 with questions.</p> <p><u>Must Specify Site/Segment:</u></p> <p><input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral</p> <p><input type="checkbox"/> Common Femoral/Superficial Femoral/Pop</p> <p><input type="checkbox"/> Tibial Vessel</p> <p><input type="checkbox"/> Iliac (Fasting)</p> <p><input type="checkbox"/> Bypass Graft Assessment <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral</p> <p>Specify Site _____</p> <p>_____</p>	<p>Venous Ultrasound</p> <p><input type="checkbox"/> Upper <input type="checkbox"/> Lower</p> <p><input type="checkbox"/> Right <input type="checkbox"/> Left</p> <hr/> <p>Upper Extremity Arterial</p> <p><input type="checkbox"/> Segmental Pressures – Waveforms</p> <p><input type="checkbox"/> Segmental Pressures – Waveforms with digits</p> <p><input type="checkbox"/> Arterial Duplex (Typically reserved for surgical consults or possible intervention) Call (603) 650-7502 with questions.</p> <p><u>Must Specify Site/Segment:</u></p> <p><input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral</p> <p><input type="checkbox"/> Subclavian <input type="checkbox"/> Radial</p> <p><input type="checkbox"/> Axillary <input type="checkbox"/> Ulnar</p> <p><input type="checkbox"/> Brachial</p> <hr/> <p>Abdominal Ultrasound (must be fasting)</p> <p><input type="checkbox"/> Renal Duplex <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral</p> <p><input type="checkbox"/> Mesenteric</p> <p><input type="checkbox"/> Abdominal Aorta Aneurysm (known / symptomatic)</p> <p><input type="checkbox"/> Abdominal Aorta Aneurysm Screening (Family Hx, No Symptoms)</p>
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