Dartmouth-Hitchcock
HEART & VASCULAR CENTER

Phone: (603) 650-8193
Fax: (603) 650-4737

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)**

Cerebrovascular

- ❑ Carotid Duplex
- ❑ Transcranial Duplex (for vasospasm & reperfusion hyperemia only)
- ❑ Temporal Artery Duplex

Lower Extremity Arterial

- ❑ ABI (Ankle Brachial Index)
  - ❍ With Toes ❍ Without Toes
- ❑ Treadmill (must have documented normal ABIs)
- ❑ Arterial Duplex (NOT for Claudication – select ABIs) (Typically reserved for surgical consults or possible intervention) **Call (603) 650-7502 with questions.**

  Must Specify Site/Segment:

  ❍ Right ❍ Left ❍ Bilateral
  - ❑ Common Femoral/Superficial Femoral/Pop
  - ❑ Tibial Vessel
  - ❑ Iliac (Fasting)
- ❑ Bypass Graft Assessment

  ❍ Right ❍ Left ❍ Bilateral

Specify Site _____

_____

Venous Ultrasound

❑ Upper ❑ Lower

❑ Right ❑ Left

Upper Extremity Arterial

- ❑ Segmental Pressures – Waveforms
- ❑ Segmental Pressures – Waveforms with digits
- ❑ Arterial Duplex (Typically reserved for surgical consults or possible intervention) **Call (603) 650-7502 with questions.**

  Must Specify Site/Segment:

  ❍ Right ❍ Left ❍ Bilateral
  - ❑ Subclavian ❑ Radial
  - ❑ Axillary ❑ Ulnar
  - ❑ Brachial

Abdominal Ultrasound (must be fasting)

- ❑ Renal Duplex

  ❍ Right ❍ Left ❍ Bilateral
- ❑ Mesenteric
- ❑ Abdominal Aorta Aneurysm (known / symptomatic)
- ❑ Abdominal Aorta Aneurysm Screening (Family Hx, No Symptoms)