WESTERN VASCULAR INSTITUTE

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VASCULAR TESTING *ONLY* ORDER FORM

(This form is to be used when you are requesting for patients to have vascular testing only at our facility.)

Patient Name & DOB: _____ Phone Number: _____

Please select the following vascular services requested along with any accompanying symptoms:

Services Requested

- ☐ Upper and Lower extremity arterial testing/ABI
- ☐ Lower extremity arterial duplex ☐ **B** ☐ **L** ☐ **R**
- ☐ Upper extremity arterial duplex ☐ **B** ☐ **L** ☐ **R**
- ☐ Lower extremity venous duplex ☐ **B** ☐ **L** ☐ **R**
- ☐ Upper extremity venous duplex ☐ **B** ☐ **L** ☐ **R**
- ☐ Carotid/vertebral/subclavian color duplex ☐ **B** ☐ **L** ☐ **R**
- ☐ Upper extremity vein mapping/surgical planning ☐ **B** ☐ **L** ☐ **R**
- ☐ Lower extremity vein mapping/surgical planning ☐ **B** ☐ **L** ☐ **R**
- ☐ Renal artery duplex
- ☐ Mesenteric/Celiac artery duplex scan
- ☐ Aorta/Iliac artery duplex scan
- ☐ IVC scan
- ☐ Post Hemo scan/dialysis graft/fistula
- ☐ Temporal artery scan
- ☐ Comments_____

Symptoms

- ☐ Peripheral artery disease
- ☐ Claudication
- ☐ Lower extremity resting pain
- ☐ Ulcer of lower extremity
- ☐ Gangrene
- ☐ Lower extremity leg pain
- ☐ Thrombosis
- ☐ Lymphedema
- ☐ Carotid Bruit
- ☐ Carotid disease
- ☐ Abdominal pain/weight loss
- ☐ Varicose veins/swelling/itching/burning/ stasis changes
- ☐ Visual disturbance/dizziness/CVA
- ☐ Other _____

Physician Signature: _____ Date: _____

Print Name: _____

**** PLEASE INCLUDE A COPY OF PATIENT'S DEMOGRAPHIC SHEET FOR REGISTRATION PURPOSES. IF A PATIENT'S INSURANCE REQUIRES A REFERRAL, PLEASE UNDERSTAND WE MUST OBTAIN ONE FROM THIER PRIMARY CARE PHYSICIAN BEFORE ANY TESTING CAN BE PERFORMED. ****