WESTERN VASCULAR INSTITUTE

Please fax all pertinent medical records to our office Fax: 480.668.5065

NEW PATIENT REFERRAL FORM

Requesting Provider: ____________________

Reason for Referral (Diagnosis): ____________________

Requesting Provider's Office Number: ____________________ Fax: ____________________

Requesting Provider's Address: ____________________

Physician Signature: ____________________ Date: ____________________

PATIENT DEMOGRAPHICS

Patient Name: ____________________

Home Address: ____________________

City: ____________________ State: __________ Zip code: ____________________

Home Phone: ____________________ Other Phone: ____________________

Date of Birth: ____________________ Insurance: ____________________ Insurance ID#: ____________________

DIAGNOSIS

- ☐ Claudication
- ☐ Rest Pain
- ☐ Ulceration Extremity
- ☐ Gangrene Extremity
- ☐ Bruit
- ☐ Carotid Stenosis
- ☐ Carotid Dissection
- ☐ Venous Insufficiency
- ☐ Phlebitis
- ☐ Family History CV Disease
- ☐ Aneurysm Disease
- ☐ Peripheral Artery Disease
- ☐ Renal-Vascular Disease
- ☐ Pain in Limb
- ☐ Swelling in Limb
- ☐ Weak Pulse
- ☐ Subclavian Stenosis
- ☐ Aortic Aneurysm
- ☐ Acute DVT
- ☐ Aortic Dissection
- ☐ Tobacco Abuse
- ☐ OTHER ____________________
- ☐ Raynauds
- ☐ Lymphedema
- ☐ TIA/Stroke
- ☐ Sycope
- ☐ Varicose Veins
- ☐ Venous Ulcer
- ☐ Spider Veins
- ☐ Chronic DVT
- ☐ Renal Disease
- ☐ Diabetes, PAD Screen

P: 480.668.5000 | F: 480.668.5065

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7165 E. University Dr.
Suite 183
Mesa, AZ 85207

Testing Center
7165 E. University Dr.
Suite 105
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Phoenix
3600 N. 3rd Ave.
Suite B
Phoenix, AZ 85013

Payson
708 S. Coeur d'Alene Lane
Suite B
Payson, AZ 85541

POS Reorder # 2105331