Vascular Ultrasound Referral Form

ADVANCED PATIENT IMAGING LLC

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APPOINTMENT

DATE: _____

TIME: _____

If you must reschedule or cancel your appointment, please give at least 24 hours notice.

_____
Referring Physician

_____
Clinic/Office

_____
Phone Fax

Patient's Name

_____
Last First MI

_____
DOB (MM/DD/YYYY) Age Weight Home Phone

Requested Vascular Ultrasound Order – Please check all that apply:

**Abdominal Aorta and Renal Artery ultrasounds require fasting 8 hours prior to study.*

U/S of:

- ❑ Abdominal Aorta
- ❑ Carotid Duplex
- ❑ Echocardiogram
- ❑ Lower Arterial Duplex w/ABI
- ❑ Lower Venous Duplex
- ❑ Renal Artery Doppler
- ❑ Upper Arterial Duplex
- ❑ Upper Venous Duplex
- ❑ Vascular Screening
- ❑ AV Mapping
- ❑ Fistula Exam
- ❑ Other (specify) _____

Clinical Indications: _____

_____

Report Delivery - ❑ Fax:_____ / ❑ Email:_____

⌧ Physician Signature: _____ Date: _____