Pad REFERRAL FORM

FAX TO: 706-221-8809

COLUMBUS VASCULAR CENTER LLC

4519 WOODRUFF RD. STE 17 ● COLUMBUS, GA 31904 ● PHONE 706-221-8999
COLUMBUSVASCULAR.COM

Please Include with Fax:

- ☐ Face Sheet
- ☐ Doctor order
- ☐ Copies of Updated Insurance Information
- ☐ Medication List
- ☐ Lab Work
- ☐ Most Recent H&P (Within 30 days)
- ☐ ABI/US Results if Completed

PATIENT'S INFORMATION (If nursing home, please check here ☐ and use that address and phone)		
Name:	DOB:	
Address:		
Phone Number:	Last Dialysis Treatment if applicable:	
Insurance:	Diagnosis ICD-10:	
Emergency Contact:	Relationship:	Phone:
Transportation Contact:	Phone:	
PCP Name:	Phone:	
Person Completing Form:		

Procedure Request:

DESIRED PROCEDURE:

- ❍ Aortogram w/run-off
- ❍ Venogram Lower Extremity
- ❍ PAD Consult Only
- ❍ PVD Consult Only
- ❍ Vein Consult (Superficial)
- ❍ EVLT
- ❍ Ultrasound - Venous
- ❍ Ultrasound – Arterial
- ❍ PADNET
- ❍ Other ______________

INDICATION:

- ❍ *Abnormal ABI*
- ❍ Claudication
- ❍ Gangrenous Toes
- ❍ Poor Circulation
- ❍ Peripheral Vascular Disease
- ❍ Varicose Veins
- ❍ Follow-up
- ❍ Pain
- ❍ Swollen Extremity
  - ❍ RT ❍ LT ❍ Both
- ❍ Other ______________

CLINICAL INFORMATION:

X-Ray Contrast Allergy?
❍ NO ❍ YES, Reaction? ______________

Diabetic
❍ NO ❍ YES, Insulin / Type?
____

Blood Thinner /Antiplatelet
❍ Coumadin ❍ Lytics ❍ Plavix
❍ Ticlid ❍ ASA
❍ Other (list):
____

Competent To Sign Consent?
❍ NO ❍ YES (If No, Whom?)
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Columbus Vascular Center

PHYSICIAN'S ORDERS:

____

PHYSICIAN / UNIT COMMENTS:

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PHYSICIAN'S SIGNATURE: ______________ **TODAYS DATE:** ______________