Vascular & Cardiothoracic Associates of MD, PA

Vascular Cardiothoracic Associates of Maryland
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PATIENT REFERRAL FORM

Dr. Sohaila M. Ali Dr. Robert J. Gordon

PATIENT INFORMATION:

Patient Name _____ Today's Date _____

Date of Birth _____ SSN _____ Cell Phone # _____

Home Phone # _____ Work Phone # _____

Patient Email _____ Insurance Plan _____

REFERRING PHYSICIAN: _____

Physician Phone # _____ Physician Fax _____

Physician Email _____

REASON FOR REQUEST: ☐ Consultation ☐ Diagnostic Testing

DIAGNOSIS / SYMPTOMS:

- ☐ Claudication
- ☐ Rest Pain
- ☐ Ulceration Extremity
- ☐ Gangrene Extremity
- ☐ Bruit
- ☐ Carotid Stenosis
- ☐ 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
- ☐ Dialysis Access
- ☐ Lymphedema
- ☐ TIA/Stroke
- ☐ Varicose Veins
- ☐ Venous Ulcer
- ☐ Spider Veins
- ☐ Chronic DVT
- ☐ Renal Disease
- ☐ Diabetes, PAD Screen
- ☐ Other _____

DIAGNOSTIC TESTING - CHECK ALL THAT APPLY

ARTERIAL TEST:

- ☐ Segmental Pressure Study w/ ABI
- ☐ Lower Extremity Arterial Duplex Ultrasound
- ☐ Aorta / Iliac Arterial Duplex Ultrasound
- ☐ Upper Extremity Arterial Duplex Ultrasound
- ☐ Carotid Arterial Duplex Ultrasound
- ☐ Dialysis Access Duplex Ultrasound
- ☐ Renal Artery Duplex
- ☐ Angiogram Location: _____

VENOUS TEST:

- ☐ Lower Extremity Venous Ultrasound
- ☐ Leg Reflux Venous Ultrasound
- ☐ Upper Extremity Venous Ultrasound
- ☐ IVC / Vena Cava Filter Ultrasound
- ☐ Venogram Location: _____