Dartmouth-Hitchcock
HEART & VASCULAR CENTER

Phone: (603) 650-8193
Fax: (603) 640-1959

❑ **URGENT**

Vascular Surgery / Laboratory Referral Form

❑ **ROUTINE**

ALL ITEMS IN THIS BOX MUST BE COMPLETED
Referral will not be processed without this information.
Referring Provider Services

Date: _____	Patient Name: _____
Referring Provider (print): _____	MRN (if available): _____
Provider Signature: _____	DOB: _____
Office phone / pager: _____	Home Phone: _____
Office Fax: _____	Work Phone: _____
Clinic name: _____	Address: _____

**** Incomplete forms will be returned ****

*****REQUIRED***** ICD-10 CODE _____

Indication(s) = Signs / symptoms – (R/O will **NOT** be accepted) _____

Question to be answered: _____

❑ Evaluate & treat (appointment with vascular provider) ❑ Diagnostic Test only (go to page2)

Evaluate & Treat

❑ **Abdominal Aortic Aneurysm** ***Imaging must be sent prior to processing referral***	**Carotid Artery Stenosis** ❑ **Symptomatic** ❑ **Asymptomstic**
❑ **Peripheral Artery Disease**	❑ **Temporal Arteritis**
Renal Artery Disease ❑ **Symptomatic** ❑ **Asymptomstic**	**Mesenteric arterial occlusive disease** ❑ **Symptomatic** ❑ **Asymptomstic**
Wound ❑ **Arterial** ❑ **Venous** ❑ **Unknown**	**AV Fistula** ❑ **New** ❑ **Established** **Dialysis days** ❑ **M/W/F or** ❑ **T/TH/Sat** **Location of Dialysis:** _____
❑ **Varicose Veins**	**Other Describe:**

Patient Name:	DOB:

(Please complete below if ordering Diagnostic Test(s) Only)

Cerebrovascular

❑ Carotid Duplex

❑ Right ❑ Left ❑ Bilateral

❑ Transcranial Duplex
(for vasospasm & reperfusion hyperemia only)

❑ Temporal Artery Duplex

Extremity - Venous

❑ Upper ❑ Lower

❑ Right ❑ Left ❑ Bilateral

❑ Venous Insufficiency, Varicose Veins

❑ Swelling, Cellulitis, PE, DVT

Lower Extremity - Arterial

❑ ABI (Ankle Brachial Index)

❑ With Toes ❑ Without Toes

❑ Treadmill (must have documented normal ABIs)

❑ Arterial Duplex (**NOT** for Claudication – select ABIs)
(Typically reserved for surgical consults or possible intervention)

Call (603) 650-7502 with questions

Must Specify Site/Segment:

❑ Right ❑ Left ❑ Bilateral

❑ Common Femoral/Superficial Femoral/Pop

❑ Tibial Vessel

❑ Iliac (Fasting)

❑ Bypass Graft Assessment

❑ Right ❑ Left ❑ Bilateral

Upper Extremity - Arterial

❑ Segmental Pressures – Waveforms

❑ Segmental Pressures– Waveforms w/ digits

❑ Arterial Duplex
(Typically reserved for surgical consults or possible intervention)

Call (603) 650-7502 with questions

Must Specify Site/Segment:

❑ Right ❑ Left ❑ Bilateral

❑ Subclavian ❑ Radial

❑ Axillary ❑ Ulnar

❑ Brachial

Abdominal Ultrasound (Must be fasting for optimal images)

❑ Renal Duplex ❑ Right ❑ Left ❑ Bilateral

❑ Mesenteric Duplex

❑ Abdominal Aorta Aneurysm (known/**symptomatic**)

❑ Abdominal Aorta Aneurysm Screening
(Family History, No Symptoms)