Dartmouth-Hitchcock
HEART & VASCULAR CENTER

Phone: (603) 650-8193
Fax: (603) 650-4737

Vascular Surgery/Laboratory Referral Form

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 _____

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

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

Question to be answered _____

Please choose: ❑ **Referral to evaluate & treat** (appt with vascular provider) ❑ **Diagnostic Test Only (go to page 2)**

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

❑ **Varicose Veins**	❑ **Other Describe:** _____ _____

Date _____ **Patient Name** _____

Referring Provider (print) _____ DOB: _____

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

REQUIRED ICD-10 Code(s) _____

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

Specify Site _____

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 Hx, No Symptoms)