CONSULTATION REQUEST / IMAGING REQUEST

OVVI
Oregon Vascular & Vein Institute

Please send/fax relevant **CHART NOTES, PREVIOUS IMAGING AND LAB REPORTS.**

If referring patient for **CONSULTATION,** please send **DEMOGRAPHICS SHEET.**

PATIENT INFORMATION:

Patient Name _____

Date of Birth _____

Home Phone # _____

Work/Cell Phone # _____

Date _____

Diagnosis _____

Symptoms _____

Additional Comments

REFERRING PHYSICIAN INFORMATION:

Referring Physician Requesting:

☐ Imaging WITH Consult Appointment
☐ Imaging ONLY

Referring MD _____

Patient's PCP _____

Phone # _____

Fax # _____

Referring Physician Order

Signature:_____

REQUESTED IMAGING:

☐ Vascular Specialist to determine imaging
☐ Referring MD to determine imaging

DOPPLER

☐
☐ ABI
☐ ABI with TP (Diabetics)
☐ ABI with Exercise
☐ Finger Brachial Index

ULTRASOUND

☐ Arterial ☐ Graft Study
- ☐ Lower Extremity
- ☐ Upper Extremity
- ☐ Left ☐ Right ☐ Bilateral

☐ Carotid
- ☐ Left ☐ Right ☐ Bilateral

☐ Venous
- ☐ Lower Extremity
- ☐ Upper Extremity
- ☐ Left ☐ Right ☐ Bilateral
- ☐ DVT
- ☐ Reflux

☐ Aorta
- ☐ Limited (AAA)
- ☐ Complete

☐ Mesenteric-SMA
☐ Renal Arterial

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