Vascular Ultrasound Laboratory Referral Form

360-733-8128 • Fax: 360-733-5354 • info@pacificvascular.com • www.pacificvascular.com

Revised 3/18/2022

TO BE COMPLETED BY REFERRING PROVIDER

Fax this page to 360-733-5354 • Please return this form to patient after faxing

❑ STAT/Urgent (Please call 360-733-8128 to schedule)
After-hours Results Phone:_____
After-hours Results Fax:_____
❑ Pacific Vascular will contact patient to schedule
❑ Patient has been scheduled

Patient Name (Last, First M) Date of Birth

Appt Date & Time Patient Phone #

Insurance Insurance ID#

ICD-10 Code(s)

Clinical History: Must have a sign, symptom or known diagnosis. No "Rule Out"

Referring Provider Name

Referring Provider Phone # Fax #

*Referring Provider Signature (Required)

LABORATORY LOCATION (Address Details on Reverse Side)

3104 Squalicum Pkwy, Suite 102, Bellingham, WA 98225
360-733-8128

TEST(S) ORDERED – PLEASE CHECK APPROPRIATE BOX(ES)

CEREBROVASCULAR:

❑ Carotid/Vertebral Duplex + Transcranial Doppler (TCD) - *Complete*
❑ Carotid/Vertebral Duplex + TCD prn* - *Conditional*
(*prn = >50% pre-cerebral stenosis; TIA/CVA symptoms)
❑ Carotid/Vertebral Duplex Only - *Abbreviated*
❑ Subclavian Steal
❑ Transcranial Doppler Only (TCD)
❑ TCD Emboli Monitoring Study
Specify: ❑ Anterior circulation ❑ Posterior circulation
❑ TCD Head Turn Vertebral Artery Compression
Intra- and extracranial evealuation of posterior circulation
❑ Temporal Arteritis *(Giant Cell Arteritis)*
Duplex of temporal, common carotid, subclavian, axillary & brachial arteries

PERIPHERAL ARTERIAL:

❑ Lower Extremity ✷
Physiologic Testing (ABI's and/or DBI's, treadmill)
Duplex: Aortoiliac & femoropopliteal prn
(prn=Abnormal ABI; treadmill not performed)
If applicable: ❑ Bypass Graft ❑ Stent Specify location: _____
❑ Customized LEA Orders Specify: ❑ Right ❑ Left (if applicable)
❑ Aortoiliac Duplex ✷ ❑ LE Duplex ❑ LE Duplex w/ABI's
❑ ABI's Only ❑ ABI's Only w/Treadmill
❑ Upper Extremity
❑ Pseudoaneurysm Evaluation Specify: ❑ Right ❑ Left ❑ LE ❑ UE
❑ Thoracic Outlet
❑ Radial Artery Mapping
❑ Raynaud's Phenomenon Specify: ❑ Hands ❑ Feet

ABDOMINAL VASCULAR: ✷

❑ Renal Artery ❑ Celiac/Mesenteric Arteries
❑ Hepato-Portal ❑ Renal/Liver Transplant
❑ Renel Vein ❑ Inferior Vena Cava/Iliac Veins
❑ Abdominal Aortic Aneurysm
Specify Indication:
❑ Follow-up/Known ❑ Endograft ❑ Symptomatic ❑ Other
❑ Medicare Screening (Age 65-75 + family hx AAA &/or male smoker)

VENOUS:

Assessment for Venous Thrombosis (DVT)

❑ Lower Extremity + Iliocaval, Bilateral - *Complete*
❑ Lower Extremity - *Conditional* ❑ Bilateral ❑ Right ❑ Left
(Conditional = bilateral & iliocaval duplex only if DVT or acute SVT in symptomatic leg, abnormal waveforms in CFV, DVT risk factors, or clinical concern for PE)
❑ Lower Extremity Only - *Abbreviated* ❑ Bilateral ❑ Right ❑ Left
❑ Upper Extremity ❑ Bilateral ❑ Right ❑ Left

Assessment for Venous Insufficiency (Reflux)

❑ Lower Extremity Reflux Specify: ❑ Right ❑ Left
❑ Iliocaval Duplex (May-Thurner Syndrome) ✷

Specialized Venous Evaluations

❑ Pelvic Congestion/Insufficiency ✷
Duplex of the Iliocaval, Ovarian and Uterine Veins
8 hrs fasting; full bladder; OTC anti-gas medication recommended
❑ Post-Ablation Lower Extremity Duplex Specify: ❑ Right ❑ Left
❑ Vein Mapping Duplex Specify: ❑ Right ❑ Left ❑ Upper ❑ Lower

DIALYSIS VASCULAR ACCESS SITE:

❑ Dialysis Access Site Evaluation Specify: ❑ Right ❑ Left
❑ Pre-op Dialysis Access Site Specify: ❑ Right ❑ Left

SCREENING EXAMS: (No clinical signs/symptoms)

Self-pay
❑ Carotid Artery Disease Screening
❑ Carotid Intima-Media Thickness Screening (CIMT)
❑ Abdominal Aortic Aneurysm Screening (Non-Medicare)
❑ Peripheral Arterial Disease Screening (ABI only)

Other Request/Info: _____

✷ *Fasting is recommended for this exam. No food or drink 8 hours prior to test to minimize bowel gas. Medications per usual.*
✷ *Diabetics eat and medicate per usual. If abdominal blood vessel visualization is poor, you may be asked to return at a later date.*

INFORMATION FOR PATIENT AND LABORATORY LOCATION DETAILS ON REVERSE SIDE

Please bring this referral form with you to your appointment

You have been scheduled for a vascular ultrasound evaluation.
This test is non-invasive and utilizes ultrasound (sound waves). Date & time of test are on the front of this form.
The length of your appointment is 1–2 hours per exam ordered.

✷ **Special Instructions for Fasting Tests (Lower Extremity Arterial & All Abdominal Exams):**
Fasting is recommended for this exam. No food or drink 8 hours prior to test to minimize bowel gas.
Medications per usual. Diabetics eat and medicate per usual. If abdominal blood vessel visualization is poor, you may be asked to return at a later date.

PACIFIC VASCULAR – BELLINGHAM

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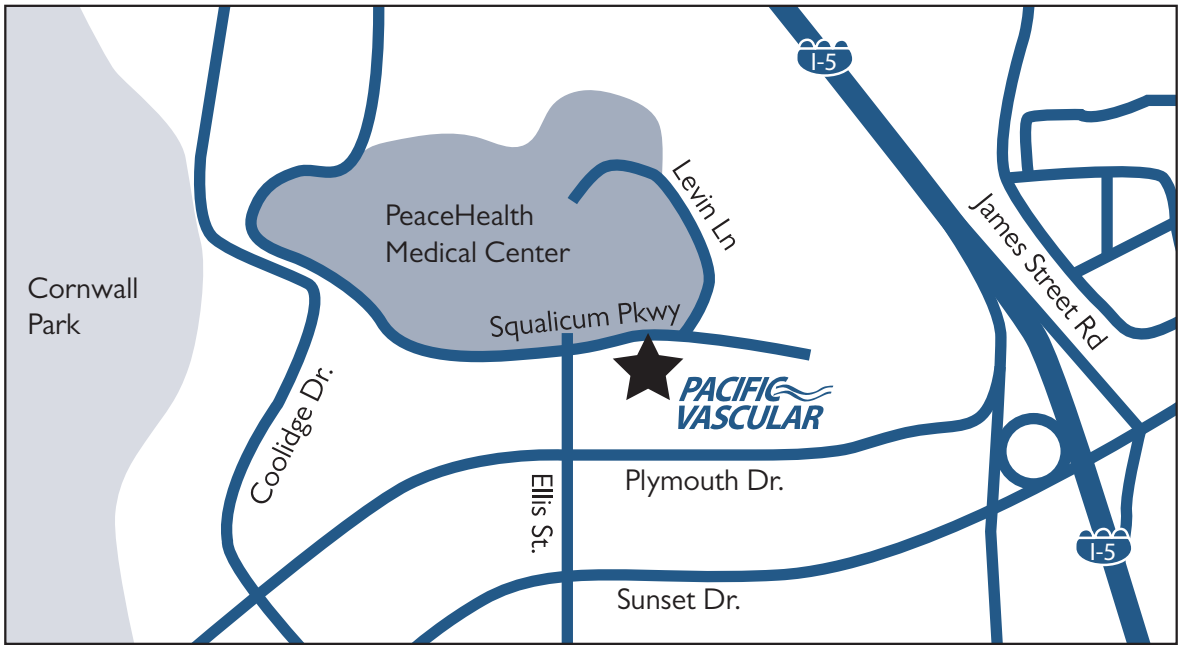

DIRECTIONS FROM I-5:

- Take exit 255 WA-542 W/E Sunset Dr
- Turn west on Sunset Dr
- Turn right onto Ellis St
- Take the 2nd right onto Squalicum Pkwy
- Vascular lab is located at the third driveway/parking lot on your right

For specific lab directions online, visit www.pacificvascular.com

PACIFIC VASCULAR

Pacific Vascular, Inc.
360-733-8128 • Toll-free in WA: 1-800-282-6516 • Fax 360-733-5354
info@pacificvascular.com • www.pacificvascular.com