SOUND VASCULAR & VEIN

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Date	Referring MD
Patient Name	DOB
Referring Facility/Contact	Patient Treatment Schedule

REFERRAL CHECKLIST

- ☑ Referral form
- ☑ Copy of Insurance Card(s)
- ☑ Patient Demographics
- ☑ Recent H&P with Labs
- ☑ Active Medication List

ACCESS TREATMENT

Arteriovenous (AV) Dialysis Access

Circle All Applicable

FISTULA : GRAFT RIGHT : LEFT

UPPER ARM : FOREARM : THIGH

Clinical Indication(s)

- ☐ Abnormal Bruit / Thrill
- ☐ Clotted Access (No Thrill)
- ☐ Prolonged Bleeding
- ☐ High Venous Pressures
- ☐ Abnormal Arterial Pressure
- ☐ Enlarging Pseudoaneurysms
- ☐ Difficult Cannulation
- ☐ Low Kt/V
- ☐ Extremity Swelling
- ☐ Pulling Clots
- ☐ Immature Fistula
- ☐ Poor Flow
- ☐ Pain
- ☐ Other_____

Catheter Dialysis Access

Circle Applicable

HEMODIALYSIS : PERITONEAL

Procedure	Clinical Indication(s)
☐ New Placement	☐ Infection
☐ Exchange	☐ Poor Flow
☐ Removal	☐ Pain
☐ Repair	☐ Other _____

Venous Access

Circle All Applicable

IMPLANTED PORT : PICC SINGLE : DUAL

Procedure	Clinical Indication(s)
☐ New Placement	☐ Infection
☐ Exchange	☐ Poor Flow
☐ Removal	☐ Pain
☐ Repair	☐ Other _____
☐ Declot/Thrombolysis	
☐ Dye Study	

VEIN SERVICES

Clinical Indication(s)

- ☐ Varicose Veins
- ☐ Leg Pain / Throbbing
- ☐ Lower Extremity Heaviness
- ☐ Skin changes / Ulceration
- ☐ Leg Edema
- ☐ Other: _____

ULTRASOUND DIAGNOSTICS

Evaluation

- ☐ Deep Vein Thrombosis (DVT)
- ☐ Upper/Lower Extremity Vein
- ☐ Varicose Vein
- ☐ Cerebrovascular (Carotid)
- ☐ Arteriovenous Fistula (AVF)
- ☐ Vein Mapping for Hemodialysis
- ☐ Dialysis Access Graft
- ☐ Renal Vascular
- ☐ Renal/Liver Transplantation
- ☐ Abdominal Aortic Aneurysm
- ☐ Upper Extremity Arterial
- ☐ Lower Extremity Arterial
- ☐ Thoracic Outlet Syndrome
- ☐ Raynaud's Phenomenon
- ☐ Mesenteric Vascular
- ☐ Hepato-Portal Evaluation
- ☐ Abdominal Evaluation

Clinical Indication and/or ICD-9 code(s)

_____

_____

_____

Allergies:

_____

_____

Yes	No	
☐	☐	Allergy to IV Contrast Dye?
☐	☐	Receiving Coumadin Therapy?
☐	☐	Able to Sign Informed Consent?
☐	☐	Translator required?
☐	☐	Transportation Arranged? (Required for Procedural Sedation)

Notes:

_____

_____

INTERVENTIONAL RADIOLOGY SERVICES

Procedure

- ☐ Inferior Vena Cava (IVC) Filter
  - ☐ New Placement ☐ Removal
- ☐ Peripheral vascular disease
- ☐ Uterine fibroid embolization
- ☐ Arterial stenting
- ☐ Percutaneous drainage
- ☐ Needle Biopsy
- ☐ Vertebroplasty

Clinical Indication(s)

_____

Thank you for this referral!

Your Appointment is:

Date: _____

Time: _____

- ☑ Do not eat or drink 4 hours prior to procedure. It's okay to take your oral medications with sips of water.
- ☑ Transportation must be arranged for patients receiving procedural sedation.
- ☑ Bring a copy of your insurance card.
- ☑ Turn paper over for directions & map.

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