Cardiothoracic and Vascular Surgeons

1010 West 40th Street
Austin, TX 78756
www.ctvstexas.com
ph 512.459.8753
fax 512.459.0586

Vascular Services Referral

Referring Physician:

_____

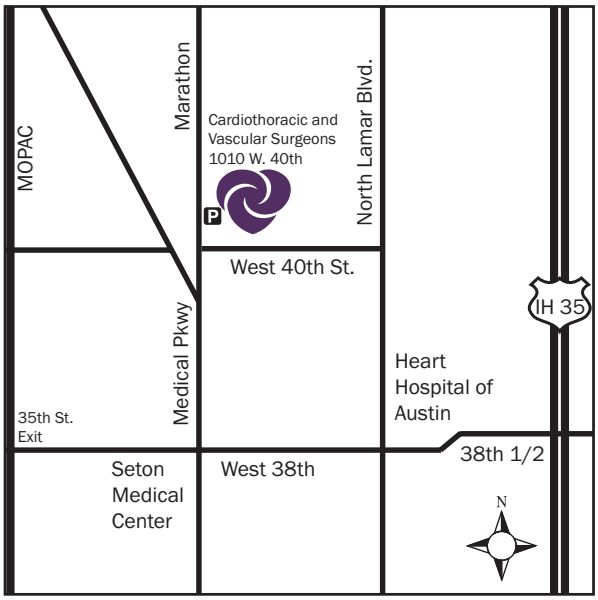
Phone (_____) _____ Fax (_____) _____

Patient Name:

_____

Phone (_____) _____ Date of Birth:_____

SSN: _____ - _____ - _____



Please indicate Consult ***or*** Vascular Studies:

☐ **Referral for Office Consultation with One of Our Board-Certified Vascular Specialists**

- ☐ Phillip J. Church, MD, FACS
- ☐ Mark T. Stewart, MD, FACS
- ☐ John K. Politz, MD, FACS
- ☐ Jeffrey S. Jobe, MD, FACS
- ☐ Stephen M. Settle, MD, FACS
- ☐ Joe K. Wells, MD, FACS
- ☐ Scott A. Seidel, MD, FACS
- ☐ Jeffrey M. Apple, MD, FACS

Reason for Referral:

- ☐ Carotid Stenosis
- ☐ Abnormal Carotid Ultrasound
- ☐ Aortic or Other Aneurysm
- ☐ Peripheral Vascular Disease
- ☐ Claudication/Leg Ischemia
- ☐ Spine Exposure
- ☐ Renal Artery Stenosis
- ☐ Establish or Evaluate Dialysis Access
- ☐ Mesenteric Ischemia
- ☐ Venous Disease
- ☐ Other_____

☐ **Request for Vascular Studies** Vascular Lab Accredited by ACR

** This form is intended to facilitate the care of your patients with vascular needs. If a non-invasive vascular study is all that is required, it will be read by the first available physician to expedite the results.*

Clinical Diagnosis_____

Arterial
- ☐ Carotid Ultrasound
- ☐ Abdominal Aortic Aneurysm Ultrasound
- ☐ Lower Extremity Arterial Doppler
- ☐ Other_____

Venous/Other
- ☐ Upper Extremity
- ☐ Lower Extremity
- ☐ Dialysis Access Evaluation
- ☐ Other_____

☐ **Request for Computed Tomography Studies**

CT Angiography **Includes Contrast**

- ☐ **Head**
- ☐ **Neck**
- ☐ **Chest**
- ☐ **Pelvis**
- ☐ **Upper Ext**
- ☐ **Lower Ext**
- ☐ **Abdomen**
- ☐ **Abd Aorta + Run Off**
- ☐ **Bilat Run Off Lower**

CT Head ☐
- ☐Without
- ☐With
- ☐Without/With

CT Orbit/Fossa/Ear ☐
- ☐Without
- ☐With
- ☐Without/With

CT Facial ☐
- ☐Without
- ☐With
- ☐Without/With

CT Soft TIssue Neck ☐
- ☐Without
- ☐With
- ☐Without/With

CT Chest ☐
- ☐Without
- ☐With
- ☐Without/With

CT Abdomen☐
- ☐Without
- ☐With
- ☐Without/With

CT Pelvis ☐
- ☐Without
- ☐With
- ☐Without/With

CT Extremity ☐

Upper
- ☐Without
- ☐With
- ☐Without/With

Lower
- ☐Without
- ☐With
- ☐Without/With

Specify Extremity: _____
Specify Right or Left: _____

✓*Provide Creatinine results within past 60 days if available*

When Completed, Please Fax to 512.459.0586