CARDIOTHORACIC AND VASCULAR SURGEONS

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# Service Requisition Form

## Hays County Office

www.ctvstexas.com

**Referring Physician:**

_______________________________________________

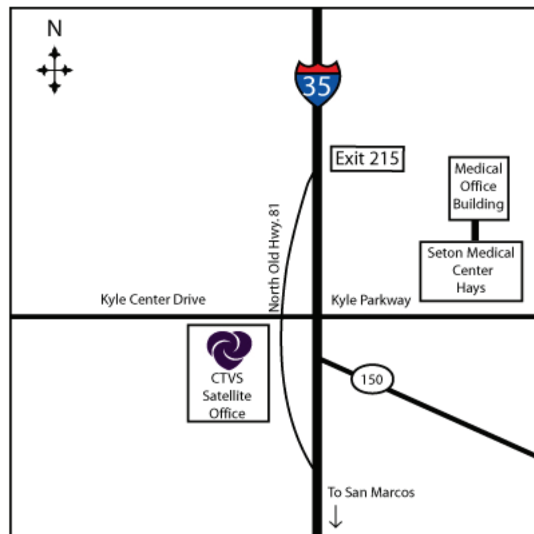
Phone (______) __________________ Fax (______) ____________________

**Patient Name:**

_______________________________________________

Phone (______) _________________ Date of Birth:____________________

SSN: _________ - ________ - ____________




## Referral for Office Consultation

### ☐ Cardiac

**Reason for Referral:**

- ☐ Coronary Artery Disease
- ☐ Mitral Valve Stenosis/Insufficiency
- ☐ Ascending Aortic Aneurysm
- ☐ Aortic Valve Stenosis/Insufficiency
- ☐ Atrial Fibrillation
- ☐ Other________________________________________________

### ☐ Thoracic/Pulmonary

**Reason for Referral:**

- ☐ Lung Nodule/Biopsy
- ☐ Lung Cancer
- ☐ Pleural Effusion
- ☐ Hyperhidrosis
- ☐ Adenopathy
- ☐ Other________________________________________________

### ☐ Vascular

**Reason for Referral:**

- ☐ Carotid Stenosis
- ☐ Aortic or Other Aneurysm
- ☐ Renal Artery Stenosis
- ☐ Abnormal Carotid Ultrasound
- ☐ Peripheral Arterial Disease
- ☐ Claudication/Leg Ischemia
- ☐ Other________________________________________________

**Doctor's Office: When Completed, Please Fax to 512.459-0586**
*****Patient must contact CTVS to schedule appointment*****