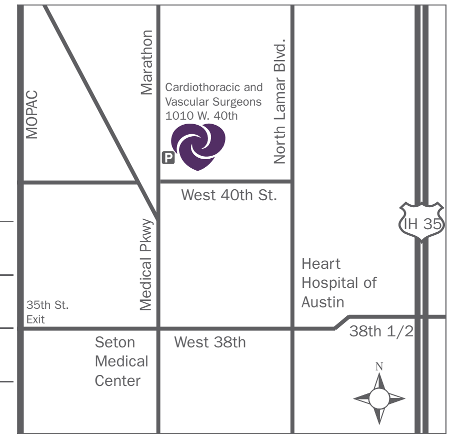
Cardiothoracic and Vascular Surgeons

Service Requisition Form

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



Referring Physician: ____________________

Phone (____) ____________ Fax (____) ____________

Patient Name: ____________________

Phone (____) ____________ Date of Birth: ____________

MD Signature Required: ____________________

☐ **Referral for Office Consultation with one of our Cardiothoracic Surgeons**

☐ Stephen J. Dewan, M.D. ☐ William F. Kessler, M.D. ☐ Eric M. Hoenicke, M.D. ☐ Jonathan A. Yang, M.D. ☐ First Available
☐ Mark C. Felger, M.D. ☐ Faraz Kerendi, M.D. ☐ Brannon R. Hyde, M.D. ☐ Robert C. Neely, M.D.

☐ **Thoracic/Pulmonary -** Daniel L. Fortes, M.D.

Reason for Referral: ____________________

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

☐ **Referral for Office Consultation with one of our Vascular Specialists.**

☐ Phillip J. Church, M.D. ☐ Jeffrey S. Jobe, M.D. ☐ Scott A. Seidel, M.D. ☐ David A. Nation, M.D.
☐ Mark T. Stewart, M.D. ☐ Stephen M. Settle, M.D. ☐ Jeffrey M. Apple, M.D. ☐ First Available
☐ John K. Politz, M.D. ☐ Joe K. Wells III, M.D. ☐ Mazin I. Foteh, M.D.

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
☐ Lower Extremity Arterial Duplex
☐ Aortic Aneurysm Ultrasound
☐ Ankle-Brachial Indices (ABI)
☐ 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