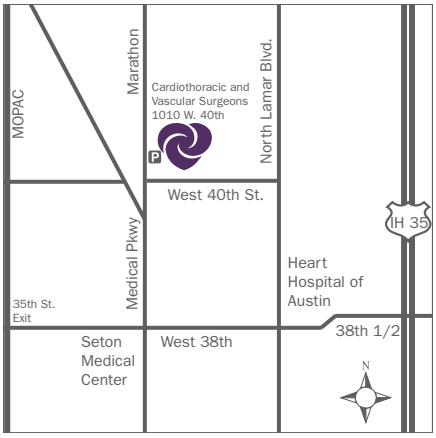
Cardiothoracic and Vascular Surgeons

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. ☐ Rachel L. Medbery, 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. ☐ 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.
☐ Jeffrey S. Jobe, M.D. ☐ Scott A. Seidel, M.D. ☐ David A. Nation, M.D.

Reason for Referral:

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

☐ 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 Chest ☐
☐ Without
☐ With
☐ Without/With

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

CT Abdomen ☐
☐ Without
☐ With
☐ Without/With

CT Facial ☐
☐ Without
☐ With
☐ Without/With

CT Pelvis ☐
☐ Without
☐ With
☐ Without/With

CT Soft Tissue Neck ☐
☐ 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