



Service Requisition Form

Referring Physician: _____

Phone _____ Fax: _____

Patient Name: _____

Phone _____ Date of Birth: _____

MD Signature Required: _____

3201 South Austin Ave.
Suite 325
Georgetown, TX 78626
ph 512.501.4287
toll free 866.703.6681
fax 512.459.0586

Referral for Office Consultation

Cardiothoracic

- | | | |
|---|--|---|
| <input type="checkbox"/> Stephen J. Dewan, M.D. | <input type="checkbox"/> Eric M. Hoenicke, M.D. | <input type="checkbox"/> Robert C. Neely, M.D. |
| <input type="checkbox"/> Mark C. Felger, M.D. | <input type="checkbox"/> Brannon R. Hyde, M.D. | <input type="checkbox"/> Brendan P. Dewan, M.D. |
| <input type="checkbox"/> William F. Kessler, M.D. | <input type="checkbox"/> W. Chance Conner, M.D. | <input type="checkbox"/> First Available |
| <input type="checkbox"/> Hunter Q. Kirkland, M.D. | <input type="checkbox"/> Jonathan A. Yang, M.D. | |
| <input type="checkbox"/> Faraz Kerendi, M.D. | <input type="checkbox"/> Jeffrey D. McNeil, M.D. | |

1180 Seton Parkway
Suite 250
Kyle, Texas 78640
ph 512.651.8420
toll free 866.746.1378
fax 512.459.0586

www.ctvstexas.com

Surgical Evaluation for:

- | | | |
|--|--|--|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Ascending Aortic Aneurysm | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Mitral Valve Disease | <input type="checkbox"/> Aortic Valve Disease | <input type="checkbox"/> Other _____ |

Thoracic/Pulmonary Rachel L. Medbery, M.D

Reason for Referral:

- | | | |
|---|--|--|
| <input type="checkbox"/> Lung Nodule/Biopsy | <input type="checkbox"/> Mediastinal Mass | <input type="checkbox"/> Diaphragm Paralysis |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Chest Wall Deformity/Pectus |
| <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Dysphasia/Achalasia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hyperhidrosis | <input type="checkbox"/> Esophageal Cancer | |

Vascular

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Phillip J. Church, M.D. | <input type="checkbox"/> Joe K. Wells III, M.D. | <input type="checkbox"/> Bradley A. Boone, M.D. | <input type="checkbox"/> First Available |
| <input type="checkbox"/> John K. Politz, M.D. | <input type="checkbox"/> Scott A. Seidel, M.D. | <input type="checkbox"/> David A. Nation, M.D. | |
| <input type="checkbox"/> Jeffrey S. Jobe, M.D. | <input type="checkbox"/> Jeffrey M. Apple, M.D. | <input type="checkbox"/> Ryan S. Turley, M.D. | |
| <input type="checkbox"/> Stephen M. Settle, M.D. | <input type="checkbox"/> Mazin I. Foteh, M.D. | <input type="checkbox"/> Taylor A. Smith, M.D. | |

Reason for Referral:

- | | | |
|--|--|---|
| <input type="checkbox"/> Carotid Stenosis | <input type="checkbox"/> Claudication/Leg Ischemia | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Peripheral Arterial Disease | <input type="checkbox"/> Establish or Evaluate Dialysis Access | <input type="checkbox"/> Non-Healing Wounds |
| <input type="checkbox"/> Renal Artery Stenosis | <input type="checkbox"/> Aortic or Other Aneurysm | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Venous Disease | <input type="checkbox"/> Spine Exposure | |
| <input type="checkbox"/> Abnormal Carotid Ultrasound | <input type="checkbox"/> 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 _____