



# Service Requisition Form

Referring Physician: \_\_\_\_\_

Phone \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Phone \_\_\_\_\_ Date of Birth: \_\_\_\_\_

MD Signature Required: \_\_\_\_\_

3201 South Austin Ave.  
Suite 255  
Georgetown, TX 78626  
ph 512.501.4287  
toll free 866.703.6681  
fax 866.591.1084

930 Kohlers Crossing  
Ste. 650  
Kyle, TX 78640  
ph 512.651.8420  
toll free 866.746.1378  
fax 866.591.1084

[www.ctvstexas.com](http://www.ctvstexas.com)

## Referral for Office Consultation

### Cardiothoracic

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

### 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. Matthew A. Gaudet, M.D. First Available

#### 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"/> John K. Politz, M.D.    | <input type="checkbox"/> Jeffrey M. Apple, M.D. | <input type="checkbox"/> Taylor A. Smith, M.D. |
| <input type="checkbox"/> Stephen M. Settle, M.D. | <input type="checkbox"/> Bradley A. Boone, M.D. | <input type="checkbox"/> Nicolas Zea, M.D.     |
| <input type="checkbox"/> Joe K. Wells, M.D.      | <input type="checkbox"/> David A. Nation, M.D.  | <input type="checkbox"/> First Available       |
| <input type="checkbox"/> Scott A. Seidel, M.D.   | <input type="checkbox"/> Ryan S. Turley, 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 \_\_\_\_\_

**When Completed, Please Fax to 866.591.1084**