PATIENT REFERRAL

VASCULAR & INTERVENTIONAL SPECIALISTS

345 W. STEAMBOAT DR., SUITE 601 Dakota Dunes, SD 57049
Phone: (605) 217-5617 Fax: (605) 217-5533

TODAY'S DATE: _____

APPOINTMENT REQUEST (Select One): ☐ ASAP ☐ First Available

PATIENT INFORMATION:

Patient Name:	Date of Birth:
Address:	Work Phone:
Insurance: *(Please send copy of Insurance card)*	Cell Phone:

REFERRING PHYSICIAN:

Physician Name:	Contact Person:
Phone:	Fax:

REASON FOR VISIT

☐ Peripheral Arterial Disease
☐ Peripheral Vascular Disease
☐ AAA
☐ Carotid Artery Stenosis
☐ Venous Insufficiency
☐ DVT/PE
☐ Mesenteric Stenosis
☐ Swelling, Lower Extremity
☐ Swelling, Upper Extremity
☐ Fistula Creation
☐ Hyperhidrosis
☐ Varicose Veins
☐ Non-Healing Wounds
☐ Renal Stenosis
☐ Other:

NOTES AND STUDIES TO SEND WITH VASCULAR REFERRAL

- Referring note
- Updated Medication List
- Copy of insurance cards
- CT or MRIs related to the appointment (abdomen, pelvis, with or without runoff) within the last year
- CTA or MRA of neck – within the last year
- ABI (Ankle Brachial Index) – within the last 6 months
- Angiogram (post-op reports- renal, peripheral, carotid) – within the last year
- Ultrasounds or Doppler Studies -carotid artery, arterial duplex of any extremities, abdominal, venous (for DVT or insufficiency studies) – within the last 6 months

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VIS Internal Use Only

SCHEDULED DATE AND TIME: _____