VASCULAR, HEART & LUNG ASSOCIATES

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Patient Name: _____ DOB: _____ Date: _____

Phone: _____ Diagnosis: _____

VASCULAR & ENDOVASCULAR SURGERY CONSULTATIONS
CARDIAC & THORACIC SURGERY CONSULTATIONS

☐ **STAT CONSULTATION** ☐ **ROUTINE REFERRAL** ☐ **SECOND OPINION**

VASCULAR

☐ Leg Pain (Claudication)
☐ Diabetic Foot / Ulcer / Infection
☐ Occlusion / Atherosclerosis Lower Extremity
☐ Deep Venous Thrombosis
☐ Abdominal Aortic Aneurysm (AAA)
☐ Tingling or Cold Feet
☐ Abnormal ABI
☐ Varicose Veins
☐ Swelling in Extremities
☐ Other: _____

VASCULAR AND ECHO ULTRASOUND STUDIES [we obtain autorizations]

☐ Ankle Brachial Index (ABI)
☐ Lower Extremity Venous (DVT)
☐ Abdominal Aortic Aneurysm / IVC / Iliacs
☐ Upper Extremity Arterial
☐ Raynaud's Phenomena
☐ Lower Extremity Arterial
☐ Varicose Vein Ultrasounds
☐ Renal Artery Scan
☐ Upper Extremity Venous
☐ ECHO
☐ Carotid Doppler
☐ Mesenteric Arteries Scan
☐ Arterial & Vein Mappings for AV Fistula
☐ Other: _____

THORACIC

☐ Lung Nodule / Infiltrate
☐ Mediastinal Lymph Nodes / Tumor
☐ Esophageal Cancer
☐ Palmer Hyperhidrosis
☐ Ascending / Thoracic Aortic Aneurysm / Dissection
☐ Emphysema Surgery
☐ Dysphagia
☐ Achalasia
☐ Other: _____

CARDIAC

☐ Mitral Valve
☐ Pericardial Effusion
☐ Aortic Valve
☐ Pacemaker Implantation
☐ Coronary
☐ Pacemaker Lead Extraction
☐ Other: _____

OTHER COMMENTS: _____

Referring Physician's Name: _____ Phone: _____

Referring Physician's Signature: _____ Fax: _____

Please fax referral, the patient's demographics, insurance card, pertinent records and reports to 480-857-8313.
Once the referral is received we will contact the patient to schedule an appointment promptly.
Thank you for your referral! We will fax back a complete consultation note.
If there are any questions, please do not hesitate to contact the office directly at 480-722-7589 or Fia Shennib at 602-478-6758.