Place Business Card or Office Stamp Here

Vascular Institute of Columbus, LLC. (VIC)

ULTRASOUND ORDER FORM

<<<<<< Circle below >>>>>>

URGENT / NON-URGENT

Fax: (614) 810-1301 **Phone: (614) 810-1300 / Facility** **Email: vascular.columbus@gmail.com**

Crystal Jimenez – Patient Coordinator **Phone: (614) 810-1302** **Email: vascularmgmt@gmail.com**

<<Please Include a copy of Patient's Demographics and Insurance Cards>>

Patient Name:_____ Relative Name (if applicable) _____

Best contact telephone number:_____ Cell Phone:_____

CIRCLE THE APPROPRIATE ITEMS **Language spoken:_____**

TEST TO BE PERFORMED AT: **(Please circle)**

Ordering DR OFFICE / PATIENT'S HOME / VIC OFFICE (6503 E. Broad St, Suite 200, Columbus, OH 43213)

AM / PM _____MON – TUES – WED – THURS – FRI – SAT - SUN

LOWER EXTREMITY VASCULAR DUPLEX STUDIES

CIRCLE ALL THAT APPLY

ARTERIAL STUDIES / ABI
Duplex scan bilateral LE arteries
Ankle Brachial Index (ABI) / Digital Toe Pressures

VENOUS W/ REFLUX STUDIES
Duplex scan bilateral LE veins
** STANDING WHEN POSSIBLE

CIRCLE ALL SYMPTOMS THAT APPLY (please indicate RIGHT/LEFT or BILATERAL as needed)

- Ulcer of lower extremity
- Gangrene of lower extremity/foot/toe
- Leg or foot pain of lower extremity
- Arteriosclerosis of lower extremity
- Peripheral Arterial Disease
- Intermittent Claudication (cramping)
- Rest / Night pain of lower extremity
- Non-palpable pedal pulse(s)
- Decrease walking/activity in 3-6 months
- PRE-OPERATIVE or POST-OPERATIVE
- Other: _____

- Diabetes Mellitus
- Smoking History
- Hyperlipidemia
- Hypertension
- History of MI / Stroke
- Raynaud's Syndrome
- Cold extremity
- Skin atrophy and/or thickened nails
- Loss or decrease of digital hair

- Varicose Vein(s) with:
  - Edema
  - Pain
  - Ulcer
  - Inflammation
- Venous stasis dermatitis
- Venous stasis with ulceration
- Venous insufficiency/HTN
- Phlebitis / Thrombophlebitis
- DVT/Thrombosis/Embolism
- Lymphedema

- Additional Pertinent Information: _____

_____

☐ SCHEDULE PATIENT FOR CONSULTATION REGARDLESS OF ULTRASOUND RESULT.

If the requested study demonstrates any positive findings, this form shall serve as my written order for consultation by a VIC affiliated interventional physician for further evaluation and patient care, including any necessary additional testing or procedures.

Physician Signature:_____ Date:_____

Physician Name:_____