

Vascular Institute of Cleveland, LLC. (VICLE) ULTRASOUND ORDER FORM

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

URGENT / NON-URGENT

Place Business Card or Office Stamp Here

Office Phone: (216) 365-9700 Fax: (216) 365-9701 Email: vascularofcleveland@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:

DR OFFICE / VICLE OFFICE (12575 Rockside Rd, Ste 102, Garfield Heights, OH 44125)

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)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">● 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: _____ | <ul style="list-style-type: none">● 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 | <ul style="list-style-type: none">● Varicose Vein(s) with:<ul style="list-style-type: none">EdemaPainUlcerInflammation● 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 VICLE affiliated interventional physician for further evaluation and patient care, including any necessary additional testing or procedures.

Physician Signature: _____

Date: _____

Physician Name: _____