INDIANA VASCULAR

REFERRAL FORM

REFERRER INFORMATION

Referring Practitioner/Clinic : _____ **Date :** _____

PATIENT INFORMATION

Full Name :

Date of Birth : _____ / _____ / _____

Address : _____

Phone Number : _____ **Cell/Home/Other**

Patient Sex : ☐ Male ☐ Female ☐ Other **Preferred Pronoun(s) (*optional*)** : _____

PATIENT SYMPTOMS / REASON FOR REFERRAL / DIAGNOSIS / ICD-10

REQUESTED EVALUATION

Peripheral Arterial Disease

- ☐ Claudication
- ☐ Nonhealing wound
- ☐ Limb discoloration
- ☐ Blue/discolored digits

Venous Disorders

- ☐ Suspected venous wound
- ☐ Varicosities (leg/arm/genitalia)
- ☐ Deep venous disorder
- ☐ Pelvic venous disorder
- ☐ Gonadal vein reflux

Other

- ☐ Hemorrhoids
- ☐ Chronic knee pain
- ☐ Spine fracture (acute/subacute)
- ☐ Uncontrolled hypertension
- ☐ Dialysis access (AVF/AVG/Permcath)

Women's Health

- ☐ Uterine fibroids
- ☐ Adenomyosis (uterine)
- ☐ Chronic pelvic pain
- ☐ Pelvic venous disorder
- ☐ Gonadal vein reflux

Men's Health

- ☐ Benign prostatic hyperplasia (BPH)
- ☐ Gonadal vein reflux
- ☐ Scrotal varicosities

☐ Not listed (please specify):

INDIANA VASCULAR
317.349.7909 317.759.5204 info@indianavascular.com
2140 North Capitol Avenue | Indianapolis, IN 46202