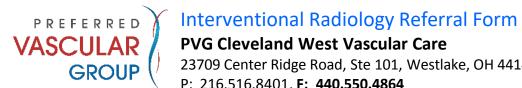
\* Required Fields



23709 Center Ridge Road, Ste 101, Westlake, OH 44145

P: 216.516.8401, **F: 440.550.4864** 

| *Today's Date:   |                          | *Completed by:                           |                                    |  |
|--|--------------------------|--|------------------------------------|--|
| *Patient Name:   |                          | *DOB:                                    |                                    |  |
| * Address:   |                          | *Referring Physician:                    |                                    |  |
| * Phone No.:   |                          | *Physician Phone:                        |                                    |  |
| *Skilled Nursing Facility (SNF):   | □ Yes □ No               | *SNF Name/Phone:                         |                                    |  |
| PERIPHERAL ARTERIAL DISEASE:   |                          |  |                                    |  |
| ☐ Patient consultation for diagnosis and treatment of peripheral arterial disease.                                 |                          |  |                                    |  |
| INDICATION: ☐ Weak pulse ☐ Claudication ☐ Pain/Rest Pain ☐ Ulcers ☐ Aneurysm ☐ Vascular Malformation ☐ Pain        |                          |  |                                    |  |
| ☐ Other/Describe:  |                          |  |                                    |  |
| WOMENS HEALTH:   |                          |  |                                    |  |
| ☐ Patient consultation for diagnosis and treatment of:   |                          |  |                                    |  |
| <b>INDICATION:</b> □ Uterine Fibroids / Uterine Artery Embolization □ Pelvic Congestion Syndrome □ Varicose Veins  |                          |  |                                    |  |
| ☐ Other/Describe:  |                          |  |                                    |  |
| VENOUS DISEASE:  |                          |  |                                    |  |
| ☐ Patient consultation for diagnosis and treatment of:   |                          |  |                                    |  |
| INDICATION: ☐ Lower Extremity Swelling ☐ DVT ☐ Varicose Veins ☐ Scrotal Varicocele / Gonadal Vein Embolization     |                          |  |                                    |  |
| ☐ Other/Describe:  |                          |  |                                    |  |
| IVC FILTERS:   |                          |  |                                    |  |
| PROCEDURE REQUESTED: ☐ IVC Filter Placement ☐ IVC Filter Removal   |                          |  |                                    |  |
| INDICATION: □ DVT □ PE □ Pre-operative Prophylaxis □ No Longer Required  |                          |  |                                    |  |
| ☐ Other/Describe:  |                          |  |                                    |  |
| PORT CATHETERS, CENTRAL LINES, AND PICCs:  |                          |  |                                    |  |
| <b>PROCEDURE REQUESTED:</b> □ Port placement □ Tunneled CVC placement □ PICC placement □ Single Lumen □ Dual Lumen |                          |  |                                    |  |
| ☐ Port/Line Removal ☐ Evaluation ☐ Revision/Replacement  |                          |  |                                    |  |
| INDICATION: ☐ Chemotherapy ☐ Plasmapharesis ☐ Antibiotics ☐ Venous Access ☐ No Longer Required ☐ Poor function     |                          |  |                                    |  |
| ☐ Other/Describe:  |                          |  |                                    |  |
| CLINICAL INFORMATION:  |                          |  |                                    |  |
| K-Ray Contrast Allergy?  | ☐ Yes ☐ No               | Reaction/Describe:                       |                                    |  |
| Diabetic?  | ☐ Yes ☐ No               |  | s, is the patient on insulin?      |  |
| Anticoagulants?  | ☐ Yes ☐ No               | If yes, what type?                       |                                    |  |
| Competent to Sign Consent? s the patient ambulatory?   | ☐ Yes ☐ No<br>☐ Yes ☐ No | If no, then whom? Wheelchair? □ Yes □ No | Stretcher? □ Yes □ No              |  |
| s the patient ambulatory:  |                          | Wileciciali: 163 110                     | Stretcher: 1 res 1 No              |  |
| Signature:   | Name                     | :  | Verbal or Fax Order received from: |  |
|  |                          |  |                                    |  |
| Please fax form with demographics, insurance information, H&P and current medication list.                         |                          |  |                                    |  |