



Interventional Radiology Referral Form

* Required Fields

PVG Cleveland East Vascular Care

23650 Commerce Park, Ste A, Cleveland, OH 44122
P: 216.273.8010, F: 216.378.9005

*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:
INDICATION: 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:

PROCEDURE REQUESTED: Port placement Tunneled CVC placement PICC placement Single Lumen Dual Lumen
 Port/Line Removal Evaluation Revision/Replacement
INDICATION: Chemotherapy Plasmapheresis Antibiotics Venous Access No Longer Required Poor function
 Other/Describe:

CLINICAL INFORMATION:

X-Ray Contrast Allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction/Describe:
Diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is the patient on insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type?
Competent to Sign Consent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, then whom?
Is the patient ambulatory?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No Stretcher? <input type="checkbox"/> Yes <input type="checkbox"/> No

Signature:	Name:	Verbal or Fax Order received from:
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Please fax form with demographics, insurance information, H&P and current medication list.