Interventional Radiology Referral Form

*Required Fields

PVG Akron Vascular Care
43 S Main Street, Suite 2, Munroe Falls, OH 44262
P: 234.349.8100, **F: 234.312.0800**

*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 ☐ Plasmapharesis ☐ Antibiotics ☐ Venous Access ☐ No Longer Required ☐ Poor function

☐ Other/Describe:

CLINICAL INFORMATION:

X-Ray Contrast Allergy? ☐ Yes ☐ No Reaction/Describe:

Diabetic? ☐ Yes ☐ No If yes, is the patient on insulin? ☐ Yes ☐ No

Anticoagulants? ☐ Yes ☐ No If yes, what type?

Competent to Sign Consent? ☐ Yes ☐ No If no, then whom?

Is the patient ambulatory? ☐ Yes ☐ No Wheelchair? ☐ Yes ☐ No Stretcher? ☐ Yes ☐ No

Signature:	Name:	Verbal or Fax Order received from:

Please fax form with demographics, insurance information, H&P and current medication list.