PREFERRED VASCULAR GROUP

Interventional Radiology Referral Form

** Required Fields*

**PLEASE CIRCLE YOUR PREFERRED LOCATION*

Akron Vascular Care
43 S Main Street, Suite 2
Munroe Falls, OH 44262
P: 234-349-8100 **F: 234-312-0800**

Cleveland East Vascular Care
23650 Commerce Park, Suite A
Beachwood, OH 44122
P: 216-273-8010 **F: 216-378-9005**

Cleveland West Vascular Care
23709 Center Ridge Road, Suite 101
Westlake, OH 44145
P: 216-516-8401 **F: 440-550-4864**

*Today's Date: _____ *Completed by: _____

*Patient Name: _____ *DOB: _____

*Address: _____ *Referring Physician: _____

*Phone: _____ *Physician Phone: _____

*Skilled Nursing Facility (SNF): ☐Yes ☐ No If yes, Name/Phone: _____

KNEE PAIN/GENICULAR ARTERY EMBOLIZATION (GAE):

Patient consultation for diagnosis and treatment of:

INDICATION: ☐ Osteoarthritis ☐Knee Pain ☐ Recurrent Hemarthrosis

☐ Other/Describe: _____

PERIPHERAL ARTERIAL DISEASE:

Patient consultation for diagnosis and treatment of:

INDICATION: ☐ Weak pulse ☐ Claudication ☐ Pain/Rest Pain ☐ Ulcers ☐ Aneurysm ☐ Vascular Malformation ☐ Pain

☐ 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: _____

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.