

**Silver Falls Dermatology**  
Vascular Lab Order Form

**Phone** 503.362.8385

**Toll Free** 1.866.599.3376

**Fax Number:** 503.362.8435

**Patient Information**

**Patient's Name** \_\_\_\_\_

**DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Patient's Home Phone** \_\_\_\_\_

**Contact Person if other than patient** \_\_\_\_\_

**Patient's Insurance \*\*** \_\_\_\_\_ **Policy No.** \_\_\_\_\_

**Reason for visit** \_\_\_\_\_  **Wet Read Requested**

**Ordering Provider Information**

**Provider** \_\_\_\_\_

**Office Phone** \_\_\_\_\_ **Office Fax** \_\_\_\_\_

**AUTHORIZED SIGNATURE (REQUIRED)** \_\_\_\_\_

**Testing Requested**

**CEREBROVASCULAR**

- Carotid Ultrasound
- TCD (Transcranial Doppler Exam)

**LOWER EXTREMITY**

- Lower Extremity Venous Ultrasound (*DVT and Insufficiency*)
- Lower Extremity Arterial Ultrasound (Claudication, LE Ischemia, Healing Potential, Pre-Operative Clearance)

**UPPER EXTREMITY**

- Upper Extremity Venous Ultrasound
- Upper Extremity Arterial Ultrasound

**ABDOMINAL VASCULAR**

- Aorta Ultrasound (AAA)
- Renal Artery Ultrasound
- Kidney Transplant Ultrasound
- Mesenteric Arteries Ultrasound

**VASCULAR ACCESS**

- Dialysis Fistula Ultrasound
- Pre-Operative Dialysis Artery and Vein Map

**OTHERS**

- Popliteal Entrapment Evaluation
- Reynaud Evaluation
- Subclavian Steal Evaluation
- Pre-CABG Mapping (GSV, IMA Radial Artery Mapping)

**Special Instructions** \_\_\_\_\_

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**\*\*Along with this form, please fax a copy of patient demographics, copy of insurance card, recent chart notes pertaining to the visit, plus any lab/path reports to the number above. Please also include if applicable: all necessary referral info including consult, diagnostics, surgery, referral number, and number of visits.**