



CONSULTATION REQUEST / IMAGING REQUEST

Vascular and Vein Center
Oregon Medical Group
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Please send relevant **CHART NOTES, IMAGING REPORTS** and **LABS** that have been performed.

If referring pt for **CONSULT APPT**, please send **DEMOGRAPHICS SHEET**.

PATIENT INFORMATION:

Patient Name _____

Date of Birth _____

Home Phone # _____

Work/Cell Phone # _____

Date _____

Diagnosis _____

Symptoms _____

Additional Comments

REFERRING PHYSICIAN INFORMATION:

Referring Physician Requesting:

- Imaging WITH Consult Appointment
 Imaging ONLY

Referring MD _____

Patient's PCP _____

Phone # _____

Fax # _____

Referring Physician
Signature: _____

REQUESTED IMAGING:

- Vascular Specialist to determine imaging
 Referring MD to determine imaging

DOPPLER

- ABI
 ABI with TP (Diabetics)
 ABI with Exercise
 Segmental Pressure
 Finger Brachial Index

ULTRASOUND

- Arterial Graft Study
 Lower Extremity
 Upper Extremity
 Left Right Bilateral
 Carotid
 Left Right Bilateral
 Venous
 Lower Extremity
 Upper Extremity
 Left Right Bilateral
 DVT
 Reflux
 Aorta
 Limited (AAA)
 Complete
 Mesenteric-SMA
 Renal Arterial