PATIENT SCHEDULING FORM

VASCULAR DISEASE

P: 904-320-0680 F: 904-320-0800

Minimally Invasive Vascular

DATE:_____ **PATIENT NAME:**_____ **DATE OF BIRTH**_____

PATIENT ADDRESS:_____ **CITY**_____ **ST:**_____ **ZIP:**_____

HOME #:_____ **CELL #:**_____ **PRIMARY INS.**_____

INDICATION:

TYPICAL ARTERIAL:

- ☐ Non-Healing Ulcers or Wounds
- ☐ Pre Amputation Consultation
- ☐ Leg Pain at Rest
- ☐ Leg Pain When Walking
- ☐ Leg Hair Loss
- ☐ Cramping of Hips, Legs, Calves & Feet
- ☐ Leg Weakness
- ☐ Leg Coldness
- ☐ Leg Numbness
- ☐ Weak Foot Pulses
- ☐ Other_____

TYPICAL VENOUS:

- ☐ Poorly Healing Ulcers
- ☐ Leg Swelling
- ☐ Leg Heaviness
- ☐ Varicose Veins
- ☐ Leg Pain
- ☐ Aching Throbbing Legs
- ☐ Skin Thickening
- ☐ Skin Discoloration
- ☐ "Restless" Leg
- ☐ "Boggy" Leg
- ☐ Other_____

LOCATION:

☐ Left Leg ☐ Right Leg ☐ Both ☐ Pelvic/Abdominal ☐ Other_____

PROCEDURE REQUESTED:

- ☐ Vascular Consultation
- ☐ Doppler Ultrasound
- ☐ ABI
- ☐ Intra Vascular Ultrasound
- ☐ Arteriogram
- ☐ Venogram
- ☐ EVLT - Laser Ablation
- ☐ RF Vein Ablation
- ☐ Vein VenaSeal
- ☐ Sclerotherapy
- ☐ Phlebectomy
- ☐ Venoplasty
- ☐ Angioplasty
- ☐ Atherectomy
- ☐ Stent Placement
- ☐ Drug Coated Balloon
- ☐ Drug Coated Stent
- ☐ Other_____

RISK FACTORS:

- ☐ Pregnancy
- ☐ >65 Years Old
- ☐ Smoking
- ☐ Diabetes
- ☐ Obesity
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ PAD, Heart Attack or Stroke
- ☐ Erectile Dysfunction
- ☐ Standing Occupation

CLINICAL INFO:

Elevated Creatinine? ☐ Yes ☐ No **Renal Insufficiency?** ☐ Yes ☐ No

Anticoagulation? ☐ Coumadin ☐ Plavix ☐ ASA ☐ Other_____

Diabetic? ☐ Yes ☐ No **Allergies?** ☐ Latex ☐ Medication ☐ Other_____

X-Ray Contrast? ☐ Yes ☐ No ☐ Reaction_____

REFERRAL CLINIC INFORMATION:

Referred by_____ **Phone**_____ **Fax**_____

Physician orders _____

Competent to Sign Consent? ☐ **Yes** ☐ **No** **If not who?**_____ **Phone**_____

If patient is forgetful or confused, a second signature is required:_____

Some or all of the following may be required to be faxed to our office:

1) Insurance Cards **2**) Most Recent H & P **3**) Patient Demographic Sheet **4**) Medication List **5**) Prescriptions for Procedure

Minimally Invasive Vascular Use Only Appointment Time/Date_____

Pickup Time/Details_____ Confirmed By:_____