ALPHA VASCULAR & ULTRASOUND CENTER

Precision Imaging. Compassionate Care.

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REFERRAL INFO & FORMS

PROVIDER REFERRAL FORM

Patient Name	**Date of Birth**	☐ Routine ☐ STAT
Phone	**Insurance**	**Member ID**
Referring Provider	**Provider Phone**	**Provider Fax**
Practice	**NPI**	**Date**

Symptoms / Clinical Indications

☐ Pain ☐ Swelling ☐ Palpable lump ☐ Claudication ☐ Varicose veins ☐ DVT rule out
☐ Abdominal pain ☐ RUQ pain ☐ Nausea ☐ Vomiting ☐ Hematuria ☐ Flank pain
☐ Foreign body ☐ Soft tissue mass ☐ Other _____

Vascular Ultrasound

☐ Carotid duplex	☐ Upper extremity venous DVT	☐ Thoracic outlet
☐ Abdominal aorta (AAA)	☐ Venous reflux	☐ Raynaud evaluation
☐ ABI/TBI	☐ Dialysis fistula/access	☐ Bypass graft surveillance
☐ Lower extremity arterial	☐ Vein mapping	☐ Stent surveillance
☐ Upper extremity arterial	☐ Renal artery	☐ Pseudoaneurysm evaluation
☐ Lower extremity venous DVT	☐ Mesenteric	

General Ultrasound

☐ Complete abdomen	☐ Kidneys	☐ Scrotal
☐ Limited abdomen	☐ Kidney & bladder with PVR	☐ Thyroid
☐ RUQ / gallbladder	☐ Urinary bladder	
☐ Liver	☐ Pelvic (transabdominal)	

Soft Tissue / Musculoskeletal

☐ Neck / lymph nodes	☐ Leg soft tissue	☐ Wrist
☐ Groin / hernia	☐ Foreign body	☐ Muscle / tendon
☐ Abdominal wall / hernia	☐ Knee / Baker's cyst	☐ Other
☐ Arm soft tissue	☐ Plantar fascia	

Other Exam Requested / Area of Concern

Clinical History / ICD-10

Referring Provider Signature _____ **Date** _____

Please include patient demographics, insurance information, and pertinent clinical notes.

STAT findings are communicated promptly.