AVA VASCULAR

Peripheral Artery Disease (PAD) Referral Form

We Bring Back The Pulse To The Foot

Please fax this form to:

951-574-6501

Patient Name:_____ **DOB:** _____

Tel Number: _____ **Caretaker Name:**_____

Clinical History:	**Signs / Symptoms:**	**Diagnosis Code:**
___ Peripheral Artery Disease	___ Claudication / Leg Cramps	___ I70.213 Claudication
___ Diabetes	___ Rest pain / Foot cramps at night	___ I70.223 Rest Pain
___ Hypertension	___ Diabetic Neuropathy	___ I70.23 Ulcer RT Leg
___ High Cholesterol	___ Cold / Numb feet	___ I70.24 Ulcer LT leg
___ Heart Disease	___ Non Healing wound on Leg / Foot	___ I70.261 Gangrene RT
___ Chronic Kidney Disease	___ Gangrene of Toes / Foot	___ I70.262 Gangrene LT
___ Smoker	___ Absent pulse in feet	

Referral for:

___ Peripheral Artery Disease (PAD) Evaluation ___ ABI & Arterial Duplex Ultrasound

Please Include the following with your fax:

___ Referral Form (This Form) ___ Patient ID (Drivers license) ___ Patient Demographics

___ Patient Insurance Card ___ Last Office visit note. ___ Recent Lab's or EKG

This is a referral for consultation. If the consultation findings require further evaluation and treatment by the physician or Physician extender including but not limited to additional tests or procedures this shall serve as my written referral.

Physician Name:_____ Date:_____

Physician Signature:_____ TAX ID:_____

WWW.AVAVASCULAR.COM, Toll Free: 1-833-LEG-CRAMP or Tel: 951-574-6500

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