ICANL Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

CardioSD

"Striving to satisfy the needs of our patients"

ICAEL Accredited Echocardiography Laboratory

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PERIPHERAL VASCULAR DUPLEX SCAN TESTING ORDER FORM

Referring Physician _____ Phone _____ Fax _____

Patient Information: (Please Fax Current Insurance Cards With Order - Front and Back.)

Name _____ Height _____ Weight _____ DOB _____

Phone (H) _____ (W) _____ (Cell) _____

SS# _____ Primary Insurance _____

Precert Obtained (if required): Initials _____ Date _____ Precert # _____

* PLEASE PERFORM

_____ Cerebrovascular Duplex Ultrasound: CAROTID

_____ Peripheral *Lower Extremity* ARTERIAL Duplex Ultrasound (LE) Specify Area: _____ L or R or Both

_____ Peripheral *Upper Extremity* ARTERIAL Duplex Ultrasound (UE) Specify Area: _____ L or R or Both

_____ Peripheral *Lower Extremity* VENOUS Duplex Ultrasound (LE) Specify Area: _____ L or R or Both

_____ Peripheral *Upper Extremity* VENOUS Duplex Ultrasound (UE) Specify Area: _____ L or R or Both

_____ Visceral Duplex Ultrasound: RENAL ARTERY

_____ Visceral Duplex Ultrasound: AORTA

_____ One Time Screening for AAA for High Risk Medicare Patients
No other AAA screening done prior, has at least one of the following:
Family history of AAA, or male age 65-75 who smoked at least 100 cigarettes

** Diagnosis may be selected from the list on the back of this form →
Please check or circle all that apply or write ICD-9 code here _____

*** Requested Location of Test:
_____ North Office: 4160 Little York Road, Ste 20 _____ South Office: 7677 Yankee Street, Ste 120, Centerville

**** √ Ordering physician signature (no stamp) _____

CardioSD use only: Scheduled by: _____ Faxed: _____
Appt. Date: _____ Appt. Time: _____ Location: _____