Vascular Ultrasound Laboratory Referral Form

inview Imaging | mint medical

Date: ______ /______ /______

Patient Name: ____________________ (LAST) ____________________ (FIRST)

DOB: ______ /______ /______ Age: ____________________

Patient Phone: (______) ____________________

ICD 10: ____________________

Clinical History: ____________________

Insurance: ____________________

Referring Provider Name: ____________________

Phone: (_____) ______________ Fax: (_____) ______________

Provider Signature: ____________________

☐ STAT ORDER After-Hours Results Ph: ____________________

After-Hours Results Fax: ____________________

Auth #: ______________ CC to: ______________

Tests Ordered - *Please check appropriate box(es)*

PERIPHERAL VENOUS (Venous Reflux and DVT):
- ☐ Upper Extremity Vein Patency (Rule out DVT)
- ☐ Lower Extremity Vein Patency (Rule out DVT)
- ☐ Reflux (Rule out Venous Insufficiency)
- ☐ Post-Ablation
- ☐ Pre-operative Vein Mapping for Bypass
- ☐ Pre-operative Dialysis Access Mapping
- ☐ Other: ____________________

CAROTID/EXTRACRANIAL ARTERIAL DUPLEX:
- ☐ Rule out Carotid and Vertebral Artery
- ☐ Stenosis
- ☐ Rule out Subclavian Arterial Stenosis
- ☐ Rule Carotid Body Tumor
- ☐ Other: ____________________

AORTOILIAC DUPLEX AND ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING:
- ☐ AAA and Iliac Artery Screening
- ☐ Aortic and Iliac Bypass Graft Surveillance
- ☐ Post-operative Endograft Surveillance
- ☐ Post-procedure Stent Surveillance
- ☐ Other: ____________________

PHYSIOLOGIC ARTERIAL EXAMS (ABI/TBI):
- ☐ Upper/Lower Extremities 3+ Levels
- ☐ Upper/Lower Extremities 1-2 Levels
- ☐ Upper/Lower Extremities 3+ Levels Stress
- ☐ Other: ____________________

PERIPHERAL ARTERIAL DUPLEX:
- ☐ Upper Extremity
- ☐ Post-procedure surveillance
- ☐ Lower Extremity
- ☐ Other: ____________________

RENAL:
- ☐ Renal Artery/Vein – Nutcracker Syndrome
- ☐ Transplant Kidney Evaluation
- ☐ Rule out Renal Artery Stenosis or Aneurism
- ☐ Other: ____________________

MESENTERIC DUPLEX:
- ☐ Superior Mesenteric Artery/Vein
- ☐ Celiac Artery
- ☐ Splenic Artery and Vein
- ☐ Other: ____________________

ILIAC VEIN DUPLEX:
- ☐ Rule out Stenosis Occlusion
- ☐ Stent Surveillance
- ☐ Other: ____________________

INFERIOR VENA CAVA DUPLEX:
- ☐ Rule out Stenosis Occlusion
- ☐ Stent or Filter Surveillance
- ☐ Other: ____________________

THORACIC OUTLET SYNDROME:
- ☐ Rule out Arterial and/or Veinous Stenosis
- ☐ Occlusion
- ☐ Other: ____________________

LIVER:
- ☐ Hepatoportal
- ☐ TIPS Evaluation
- ☐ Hepatic Veins
- ☐ Celiac Artery
- ☐ Splenic Artery/Vein
- ☐ Other: ____________________

TEMPORAL ARTERY DUPLEX:
- ☐ Rule out Temporal Arteritis
- ☐ Other: ____________________

PSEUDOANEURYSM EVALUATION:
- ☐ UPPER/LOWER EXTREMITY:
- ☐ Upper Extremity
- ☐ Lower Extremity
- ☐ Other: ____________________

RAYNAUD'S EVALUATION:
- ☐ Rule out Raynaud's Disease
- ☐ Rule out Raynaud's Syndrome
- ☐ Other: ____________________

Other Request/Info:

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Mint Medical Vascular Ultrasound Services are available at our Oakland location:

1300 Clay Street
Suite 165
Oakland, CA 94612

Monday - Friday
8:00 AM - 5:00 PM

510.823.2211

888.480.6615

Mint Medical services are provided at the Inview Imaging clinic in Oakland.

www.inviewimaging.com

FOR PHYSICIAN USE ONLY

You may submit this form online at our secure submission portal by simply scanning this QR code.