• ORDERS •

VASCULAR SURGERY LABORATORY

STANFORD VASCULAR LABORATORY
DIVISION OF VASCULAR SURGERY
VASCULAR CENTER, #H-3600, M/C 5642
Schedule Appt: (650) 725-5227 FAX: (650) 723-3600

Medical Director: E. John Harris, Jr. M.D. Technical Director: Mara L. Maldutis, BS, RVT

The Stanford Vascular Laboratory is a specialized diagnostic facility that has been accepted by the Intersocietal Commission for the Accreditation of Vascular Laboratories. Its purpose is to serve health care providers and their patients by utilizing advanced noninvasive diagnostic medical technology while ensuring high quality results. Clinically skilled Registered Vascular Technologists with specialized training perform examinations.

Patient Referral Information: Today's Date: _____

Patient Name: _____ MR# _____
Attending Physician (please print): _____ MD Phone/Pager: _____

Do not use "rule out", "probable", or "screening for" diagnosis. Medicare pays only for tests, which it considers medically necessary for the diagnosis and treatment of the patient. **Ancillary services are expected to have a diagnosis, symptom, or complaint on file that shows medical necessity.**

DIAGNOSIS (ICD-9-CM)CODE REQUIRED: 1._____ 2._____

Vascular Laboratory Examination

___ **CAROTID/VERTEBRAL ARTERY ULTRASOUND**
- ___ CVA/TIA: _____
- ___ Bruit **L R Bilat**
- ___ Amaurosis Fugax **L R Bilat**
- ___ Subclavian Steal
- ___ s/p Thromboendarterectomy/Stent
- ___ Carotid Stenosis
- ___ Vasospasm
- ___ Syncope/Vertebrobasilar Disease
- ___ Fibromuscular Hyperplasia (FMH)
- ___ **Other** _____

___ **ABI'S (PRESSURES & WAVEFORMS)**
- ____ Lower Extremity
- ____ Upper Extremity
- ___ Claudication
- ___ Rest Pain
- ___ Gangrene or Ulcer
- ___ Nonhealing Wound
- ___ PVD unspecified
- ___ **Other** _____

___ **ARTERIAL DUPLEX**
- ____ Lower Extremity **L R Bilat**
- ____ Upper Extremity **L R Bilat**
- ___ Femoral Bruit **L R Bilat**
- ___ s/p Arterial Bypass/Stent
- ___ Hx of Popliteal/Femoral Aneurysm
- ___ **Other** _____

___ **OTHER EXAM:** _____

___ **VENOUS ULTRASOUND**
- ___ Left ___ Right ___ Bilat
- __ Lower Extremity __ Upper Extremity
- ___ Edema/Pain
- ___ Hx. Deep Venous Obstruction
- ___ Hx. Superficial Thrombophlebitis
- ___ s/p Thrombolysis/Stent
- ___ Pulmonary Embolus
- ___ Venous Insufficiency (**VRF Only**)
- ___ Vein Mapping **Bypass AVF**
- ___ **Other** _____

___ **ABDOMINAL AORTA ULTRASOUND**

___ **ILIAC ARTERY ULTRASOUND**
- ___ Increased Pulsatility/Back Pain
- ___ Distal Embolus
- ___ AAA
- ___ Hx. Lower Extremity Aneurysm
- ___ s/p AAA Stent/Iliac Stent
- ___ IVC or Iliac Vein Obstruction
- ___ Other _____

___ **RENAL ULTRASOUND**

___ **MESENTERIC ULTRASOUND**
- ___ Mesenteric Angina
- ___ s/p Mesenteric Bypass or Stent
- ___ Uncontrollable HTN
- ___ Renal Artery Stenosis
- ___ s/p Renal Transplant **L R**
- ___ s/p Renal Artery Bypass/Stent **L R**
- ___ **Other** _____

MD Signature: _____ ***Date:***_____

MM (04/08)