COASTAL VASCULAR
INSTITUTE

1411 Physicians Drive
Wilmington, NC 28401
Tel (910) 343-0811
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VASCULAR PHYSICIAN REFERRAL/ULTRASOUND

Referring Physician _____ **Signature** _____

Patient Name _____ **Patient DOB** _____

Patient Phone _____

Call Report to Number _____ **Fax Report to Number** _____

Please Select a CVI Vascular Surgeon: **WEATHERFORD** **ESKEW**

Indication for Test/Consult _____

Diagnosis/ICD-10 Code _____

(Diagnosis code must match study)

- ☐ **Physician Consult only**
- ☐ **Physician Consult with Ultrasound (Please Check Test(s) Needed Below)**
- ☐ **Ultrasound/Vascular Test only (Please Check Test(s) Needed Below)**
- ☐ **Free Vein Consult (Varicose & Spider veins only)**

Vascular Ultrasound Test (Must specify L, R, or BILAT when applicable)

- ☐ **Abdominal Aorta Duplex **_Diet Required_**
- ☐ **ABI's ___UNI (___L ___R) ___BILAT; if abnormal LEA will be performed**
- ☐ **ABI with Exercise**
- ☐ **Carotid Duplex ___UNI (___L___R)___BILAT**
- ☐ **Cold Thermometry Testing to evaluate for Raynaud's Disease ___Lower Ext ___Upper Ext.**
- ☐ **Groin/Pseudoaneurysm Arterial Duplex ___UNI (___L___R)**
- ☐ **Hemodialysis Fistula/Graft Duplex (Existing Dialysis Fistula/Graft Only)**
- ☐ **Mesenteric Artery Duplex **_Diet Required_**
- ☐ **Peripheral Arterial Disease Limited Screenings: _____ABI _____Aorta _____Carotid**

(Patient Pay: Only $35 Per Screening or $100 for All 3 Screening Exams)

- ☐ **Renal Artery Duplex ___UNI (___L___R)___BILAT **_Diet Required_**
- ☐ **Soft-Tissue Ultrasound**
- ☐ **Temporal Artery Duplex**
- ☐ **UEA___UNI (___L___R)___BILAT**
- ☐ **Upper Extremity Vein Mapping & Artery Mapping Bilateral/Dialysis Access (Pre-op)** (Patient also needs physician consult)
- ☐ **Venous Duplex (for DVT) ___Lower ___Upper Extremity___UNI (___L ___R) ___BILAT**
- ☐ **Venous Duplex (for venous insufficiency) UNI (___L ___R)**
- ☐ **Wrist/Brachial Index (WBI)**

Please send imaging, office notes, and demographics with your referral.