○ Krishna Mannava, MD, FACS, RPVI
○ Evelyn Weaver, PA-C, MSPAS

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Date: ______ How urgently does this referral need scheduled: ○ Critical ○ 2-3 Weeks ○ Non-Urgent

Referring Provider: ______ Phone: ______ Fax: ______

Primary Provider: ______ Phone: ______ Fax: ______

Patient Name: ______ DOB: ______

SSN: ______ Patient Phone: ______ Alternate Phone: ______

Patient Address: ______

Primary Insurance: ______ ID No: ______ Group No: ______

Secondary Insurance: ______ ID No: ______ Group No: ______

Reason for consultation or procedure requested: ______

Please Schedule Consult for:	Select any requested vascular testing:
○ Deep Vein Thrombosis (DVT)	○ Venous Duplex to assess for DVT
○ Peripheral Arterial Disease (PAD)	○ Arterial Duplex & ABI
○ Varicose Veins / Chronic Venous Insufficiency	○ Venous Duplex to assess for venous reflux
○ Carotid Artery Disease	○ Carotid Artery Duplex
○ Aneurysm (abdominal aortic, thoracic, peripheral)	○ Abdominal Aorta Duplex
○ Mesenteric/Renal Artery Atherosclerosis	○ Mesenteric or Renal Artery Duplex
○ Dialysis Access	○ Access Duplex or Vein Mapping (see section below)

PLEASE SEND CURRENT MEDICATIONS AND MOST RECENT LABS

This section is for dialysis access consults

Reason for consult: ______

Type of existing access: ______ Dialysis Unit location: ______ Days & time: ______

Unit phone: ______ Nursing facility phone if applicable: ______

Appointment Date: ______

Thank you for referring your patient to Vive Vascular.