









VASCULAR SURGERY AND INTERVENTIONAL RADIOLOGY

REFERRAL AND ORDER FORM

Call 770.919.5238 (office) or Fax this Referral/Order Form to: 770.954.5168

Referring to (please circle one): DR. DAVID ALLISON | DR. PAUL B. JONES | DR. DAVID PENN PATIENT INFORMATION Date of Birth: Primary Phone #: Insurance Co. Name:_____ REFERRING PHYSICIAN INFORMATION Physician's Name: Phys. Phone #: ______ Fax #: _____ Phys. Signature: _____ Insurance Referral Required: ☐ Yes ☐ No **ARTERIAL DISEASE WOMEN'S HEALTH OTHER PLEASE LIST** ☐ Peripheral Arterial Disease ☐ Fibroids ☐ Leg Ulcers/Non-healing Wounds ☐ Pelvic Congestion ☐ Aneurysm ☐ Superficial Venous Disease **ULTRASOUND** ☐ Carotid Disease □ DVT **DIALYSIS** □ Venous Extremity **VENOUS DISEASE** ☐ Fistulagram ☐ Arterial Extremity ☐ Leg Swelling/discoloration ☐ Thrombectomy ☐ Carotid ☐ Leg Ulcers ☐ Fistula/ Graft Creation ☐ Aortic Aneurysm ☐ Fistula/ Graft Revision □ IVC Filter Placement ☐ Pelvic ☐ IVC Filter Removal ☐ Dialysis Catheter Plct/Removal ☐ Dialysis Vein Mapping □ DVT **CATHETER PLACEMENT** ☐ Deep Venous Disease ☐ Superficial Venous Disease ☐ Port Placement/Removal ☐ Tunneled Extended Line Plct. ☐ Hickman Catheter Placement **ADDITIONAL INFORMATION**

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