

PRECISION VASCULAR KENTUCKY

PERIPHERAL ARTERIAL DISEASE(PAD)/VIENS REFERRAL FORM

 STAT URGENT NON-URGENT

Patient Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Caretaker/Relative Name: _____

PAD Risk Evaluation	Score
Have Diabetes	7
Have any wounds or ulcers on foot or lower leg	6
Have Neuropathy	4
Have High Cholesterol	3
Over 65	6
Over 50	4
History of Smoking	5
History of Lower Extremity Revascularization	5
History of Hypertension	4
History of resting leg pain or foot pain	4
History of one foot ever colder than the other	4
History of Heart Attack or Stent	3
Total Score	

If patient scores above 10, refer for Vascular Evaluation

Referring: Yes No

Additional Clinical History and Symptoms (Check all that apply)	
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Pain in foot or leg at night which is relieved by sitting on side of bed or walking	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Pain when walking which is relieved on rest	<input type="checkbox"/> Absent Foot Pulse

Diagnosis (Check all the apply)			
	RT Leg	LT Leg	Bilateral
Claudication	<input type="checkbox"/> I70.211	<input type="checkbox"/> I70.212	<input type="checkbox"/> I70.213
Rest Pain	<input type="checkbox"/> I70.221	<input type="checkbox"/> I70.222	<input type="checkbox"/> I70.223
Ulcer	<input type="checkbox"/> I70.23	<input type="checkbox"/> I70.24	
Gangrene	<input type="checkbox"/> I70.261	<input type="checkbox"/> I70.262	<input type="checkbox"/> I70.263

Please include: ID Insurance Demographics Last Office Note Referral (this form)

Services Requested	
<input type="checkbox"/> Peripheral Vascular Evaluation	<input type="checkbox"/> Possible CLI**
<input type="checkbox"/> Arterial Duplex Evaluation of Extremities <u> </u> L <u> </u> R <u> </u> B	<input type="checkbox"/> Surgical Clearance <input type="checkbox"/> ABI/TBI

****CLI (Critical Limb Ischemia) treatment is very important to all payors. Please note it in the chart on the left if applicable.**

This is a referral for a consultation and examination. Should the requested study demonstrate any positive findings, this shall serve as my written referral to the interventional physician for further evaluation and patient care, including any necessary additional tests or procedures.

Referring Physician Signature: _____ Date: _____

Print Name: _____

Precision Vascular Kentucky
400 Executive Park Louisville, KY 40207

Phone: (502) 365-4151 | Fax: (877) 837-3834 | Email: referrals@precisionvascularkentucky.com

PRECISION VASCULAR KENTUCKY

Vein Symptom Evaluation	Y/N
Are your legs swollen, painful, red or warm to the touch?	Y/N
Do your legs feel heavy, tired, restless or achy?	Y/N
Are you experiencing any non-healing ulcers?	Y/N
Have you had any blood clots in a vein that caused inflammation or irritation?	Y/N
Do you have varicose veins (veins that are enlarged or swollen) in the legs?	Y/N

Additional History
<input type="checkbox"/> Previous vein treatment
<input type="checkbox"/> History of DVT

Services Requested
<input type="checkbox"/> Venous Vascular Evaluation <input type="checkbox"/> Venous Duplex __L __R __B
<input type="checkbox"/> Venous Insufficiency Scan of Extremities __L __R __B

Diagnosis (Check all that apply)
<input type="checkbox"/> Leg swelling (M79.89) <input type="checkbox"/> Pain in right leg (M79.604) <input type="checkbox"/> Pain in left leg (M79.605) <input type="checkbox"/> Venous Stasis (I87.8) <input type="checkbox"/> Venous Insufficiency (I87.2) <input type="checkbox"/> Varicose Veins (I83.9) <input type="checkbox"/> Non-pressure chronic ulcer of skin of other sites with unspecified severity (L98.499)

A NOTE ABOUT INSURANCE PAYORS

We accept most insurance: Medicare, Medicaid, Anthem, and many others. Most plans require pre-authorization.

IMPORTANT: We are able to receive authorization even from plans that we do not routinely accept. **PLEASE SEND ALL INSURANCE TYPES.** We will attempt to get authorization if the patient needs additional treatment.

Precision Vascular Kentucky
400 Executive Park Louisville, KY 40207

Phone: (502) 365-4151 | Fax: (877) 837-3834 | Email: referrals@precisionvascularkentucky.com