APEX ENDOVASCULAR
ADVANCED PROCEDURAL EXPERTS LLC

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PHYSICIAN REFERRAL FORM

Please FAX recent clinical notes, imaging, test results:
Phone: (970) 694-2650 - Fax: (877) 370-4486

Patient Name:_____ **Patient Phone:**_____
DOB:_____ **Today's Date:**_____

Referring Physician's Name:_____
Referring Physician's Signature:_____
Office Phone:_____ **Office Fax:**_____

Reason For Referral:_____

_____

_____

Peripheral Arterial Disease

- ☐ Leg pain/claudication
- ☐ Non-healing wound

Dialysis Access/Management

- ☐ Fistulogram
- ☐ Fistula declot
- ☐ Tunneled HD Catheter Placement
- ☐ Tunneled HD Catheter Removal

Men's Health

- ☐ Varicocele Embolization

Women's Health

- ☐ Pelvic Pain
- ☐ Pelvic Congestion Syndrome
- ☐ Uterine Fibroid Embolization

Venous Disease

- ☐ Varicose Veins
- ☐ Leg Swelling
- ☐ Venous Insufficiency
- ☐ Venous Ulceration
- ☐ DVT

Spine Pain

- ☐ Kyphoplasty/Vertebroplasty
- ☐ Epidural Steroid Injection (ESI)

Diagnostic Ultrasound

- ☐ Doppler Venous Ultrasound
- ☐ Doppler Venous Reflux US
- ☐ Doppler Arterial US
- ☐ Carotid Ultrasound
- ☐ Abdominal Aortic Ultrasound