Fishkill
Endovascular Center
Affiliated with American Endovascular

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# PATIENT REFERRAL INFORMATION

## Peripheral Arterial Disease (PAD)

### To be completed by referring physician (please print all information)

PATIENT NAME (first and last): _____

PHONE (home): _____ (mobile): _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

LANGUAGE ACCOMMODATION? ___ YES ___NO Specify: _____

REFERRING PROVIDER: _____ NPI#: _____

PHYSICIAN SIGNATURE: _____ DATE:_____

### Reason for Evaluation
please check reason/s and circle leg/s

- ☐ Leg Pain when walking R L
- ☐ Leg Pain at rest R L
- ☐ Non-healing Leg/Foot Ulcer R L
- ☐ Venous Ulceration R L
- ☐ Varicose Veins R L
- ☐ Leg Swelling R L

### Cardiovascular Risk Factors
please check all that apply

- ☐ DM
- ☐ HTN
- ☐ Dyslipidemia
- ☐ Active/Prior Smoker
- ☐ HX of CAD
- ☐ HX of TIA/CVA
- ☐ CKD
- ☐ Prior DVT
- ☐ Other _____

**To refer a patient, please fax completed form to: 845.896.1990**

**Please include patient demographics, H&P, insurance card and any vascular studies which have been performed.**

**Please make patient aware that he/she will be contacted by Fishkill Endovascular Center to schedule the vascular consultation.**

60 Merritt Boulevard, Suite 107, Fishkill, New York 12524
PHONE: 845.896.1900 | FAX: 845.896.1990 | americanendovascular.com

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