



John Rundback, MD • Kevin Herman, MD

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: 973.947.6647

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 NJ Endovascular & Amputation Prevention to schedule the vascular consultation.