SOUND VASCULAR & VEIN

Patient Referral form

32014 32nd Avenue, S Federal Way, WA 98001
Phone: 253-874-7107
Fax: 253-874-1923

Peter Gregory, MD Aparna Baheti, MD Laura Slee, ARNP

Date: _____

Patient Information

Name _____
Date of birth _____
Primary number _____
Secondary number _____
Insurance name _____
Insurance ID _____

Provider Information

Referring Provider _____
Phone number _____
Needs Translator? _____
Needs Transportation? _____
Able to sign consents? _____

Reason for Consult

- ☐ Wound
- ☐ Claudication / Rest Pain
- ☐ Varicose Veins
- ☐ Chronic or Suspected DVT
- ☐ Aneurysm
- ☐ IVC Filter Retrieval or Placement
- ☐ Peripheral Neuropathy

Embolization

- ☐ Uterine Fibroids
- ☐ Pelvic Pain
- ☐ Varicocele
- ☐ Knee Osteoarthritis
- ☐ Prostate
- ☐ Hemorrhoids

Other

- ☐ Port
- ☐ Vertebral Compression Fracture
- ☐ Pre-Surgical Evaluation
- ☐ Other _____

Ultrasound

☐ Right ☐ Left ☐ Bilat

- ☐ Lower Extremity Arterial / ABI
- ☐ Lower Extremity Venous (Rule out DVT)
- ☐ Lower Extremity Venous Reflux (Varicose Veins)
- ☐ Pelvic Venous Ultrasound
- ☐ IVC / Iliac Veins
- ☐ Abdominal Aortic Aneurysm

Additional Comments:

_____
_____
_____
_____

PLEASE FAX REFERRAL TO 253-874-1923 WITH DEMOGRAPHICS, INSURANCE INFORMATION, RECENT CHART NOTES & MEDICATION LIST

Not sure what to order? Call 253-874-7107 to speak with our staff.

IAC Accredited Facility – Vascular Testing

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.

Thank you for this referral!