





CONSULT REQUEST / ORDER FORM

PATIENT INFORMATION

Patient Name	DOB/
Patient Primary Phone	Patient Secondary Phone
Insurance	Insurance (Secondary)
Referring PhysicianReason for Referral:	Referring Physician Phone
STAT Request Call Report to #	Fax Report to #
Referring Physician's Signature	///
EVALUATE AND TREAT	
ARTERIAL DISEASE Peripheral Arterial Disease (non-healing wound, foot pain, claudication, gangrene, blue toes, ischemic changes)	MEN'S HEALTH BPH / Prostate Artery Embolization Varicocele Embolization
VENOUS DISEASE Varicose Veins / Venous Insufficiency (non-healing ulcer, leg pain, leg swelling, varicose veins, chronic Deep Vein Thrombosis) May-Thurner Syndrome Eval/Test	WOMEN'S HEALTH Uterine Fibroids / Uterine Artery Embolization Pelvic Congestions / Ovarian Vein Embolization
ORTHOPEDIC Frozen Shoulder Embolization Knee Osteoarthritis / Genicular Artery Embolization	PAIN Diabetic Neuropathy / Spinal Cord Stimulator Spinal Fractures / Vertebroplasty or Kyphoplasty
Notes:	

DISCLAIMER: Health-related information on this brochure including text, graphics, images, and other material is for educational purposes only and therefore not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. If you think you may have a medical emergency, call your doctor or 911 immediately.