EMIS | Elite Minimally Invasive Specialists

VASCULAR EVALUATION FORM

Patient Name: _____ Today's Date: _____

Patient Phone: _____ Patient DOB : _____

Emergency Contact: _____ Phone: _____

Primary Insurance: _____ ID # _____

Referring Physician: _____ Phone : _____

☐ Urgent (within one week) ☐ Routine (within two weeks)

PATIENT SYMPTOMS:

☐ Leg/ Ankle Swelling ☐ Leg Pain/ Leg Aching ☐ Varicose Veins

☐ Bleeding Veins ☐ Leg Skin Discoloration ☐ Leg/Ankle Ulcer Wound

☐ Recurring Cellulitis ☐ Other: _____

TREATMENT:

☐ Arterial Consult ☐ Venous Consult ☐ US For Venous Insufficiency

☐ SVT/DVT (Mon/Thur)

DIAGNOSIS :

DX: _____ DX: _____

HX:

☐ DIABETIC ☐ CVA ☐ ANTICOAGULATION ☐ HYPERTENSION

☐ SMOKING ☐ CAD ☐ HIGH CHOLESTEROL ☐ OTHER: _____

ADDITIONAL COMMENTS:

_____

_____

_____

Thank You for The Opportunity to Participate In Your Patient's Health Care

PLEASE ATTACH PATIENT:

DEMOGRAPHIC SHEET, RECENT H&P, DIAGNOSTIC IMAGES, LABS (INCLUDING COAGULATION), MEDICATION LIST, INSURANCE CARDS

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