VASCULAR REFERRAL FORM

Please circle: ELECTIVE REFERRAL URGENT REFERRAL (24 HRS)

Vascular Midtown
3713 Benson Drive
Suite 201
Raleigh, NC 27609
919-235-6520
Fax 919-235-6590

- ☐ 1st available
- ☐ Dr. Kirk Charles
- ☐ Dr. James Fogartie
- ☐ Dr. Joseph Salfity

Vascular Raleigh
3000 New Bern Avenue
Suite 1130
Raleigh, NC 27610
919-235-6520
Fax 919-235-6590

- ☐ 1st available
- ☐ Dr. Kirk Charles

Vascular Cary
210 Ashville Avenue
2nd Floor
Cary, NC 27518
919-235-6520
Fax 919-235-6590

- ☐ 1st available
- ☐ Dr. Jacek Paszkowiak
- ☐ Dr. Joseph Salfity

DIAGNOSIS (Circle)

AAA (aneurysm)
Carotid artery disease
ESRD
PAD (peripheral artery disease)
Renal artery disease
Venous disease (DVT)
Varicose veins / insufficiency

VASCULAR TESTING (Circle)

Aorta duplex
Carotid duplex
ABI / arterial duplex
Renal artery duplex
Venous duplex / vein mapping
Venous reflux testing

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

City/State/Zip: _____ Phone: _____

INSURANCE INFORMATION

Insurance Name: _____

Policy number / group number: _____

Policyholder name: _____

REFERRING PHYSICIAN INFORMATION

Name: _____

Practice: _____

Name of Person completing this form: _____