INTERVENTIONAL • VASCULAR • FIBROID • ONCOLOGY

3186 Village Dr., Ste 201
Fayetteville, NC 28304
Phone (910) 486 - 5700
Fax: (910) 486 - 5950

Valley Radiology
Vascular & Interventional

Fax Referrals: (910) 486-5950
STAT REFERRAL: Yes / No
STAT Contact:

Patient Name:	DOB:	Appt Date:
Phone:	Alt. Phone:	Appt Time:
Patient Address:		**Diagnosis (ICD-10)**
Insurance Primary:	ID:	**Authorization #**
Provider:		**Previous Imaging:**
Practice:	Phone:	Fax:
Referral Coordinator:	Phone:	Fax:

CONSULTATION | PROCEDURE | BIOPSY | ULTRASOUND

Arterial Consult
- ☐ PAD / PVD / Claudication / LE Ulcer
- ☐ Renal / Visceral Stenosis or Aneurysm
- ☐ Other_____

Arterial Duplex
☐ Eval & Treat
- ☐ Upper Extremity ☐ Lower Extremity
- ☐ Left ☐ Right ☐ Bilateral

☐ **Ankle-Brachial Index**
Includes Segmental and Toe Pressures

☐ **Carotid Duplex**

Venous Consult
- ☐ Venous Insufficiency (General Consult / Edema
Edema/LE Skin Discoloration/General consult
- ☐ DVT
- ☐ May-Thurner Syndrome
- ☐ IVC Filter Placement / Removal
- ☐ Other_____

Venous Duplex
☐ Eval & Treat
- ☐ DVT ☐ Venous Insufficiency ☐ Both
- ☐ Upper Extremity ☐ Lower Extremity
- ☐ Left ☐ Right ☐ Bilateral

Vascular Malformation Imaging and Intervention
Specify_____

Hemodialysis Access Maintenance
(See Dialysis Referral Form)

Gynecology Consult
- ☐ Uterine Fibroids
- ☐ Transvaginal Pelvic Ultrasound
(Order for Fibroid consult if Imaging unavailable)
- ☐ Pelvic Congestion
- ☐ Other_____

Urology Consult
- ☐ Varicoceles
- ☐ Enlarged Prostate (BPH)
- ☐ Renal Artery Angioplasty / Stenting
- ☐ Other_____

Orthopaedic
- ☐ Arthrogram
Specify _____ ☐ Left ☐ Right
- ☐ Joint Injection
Specify _____ ☐ Left ☐ Right
- ☐ Radiofrequency Ablation - Osteoma

Spine Consult
- ☐ Vertebral Compression Fracture / Kyphoplasty
(DEXA / MRI required for consultation)
- ☐ Radiofrequency Ablation - Vertebral Neoplasm

Oncology Consult
Specify Type_____
- ☐ Ablation
- ☐ Catheter Directed Therapy / Embolization

Gastroenterology
- ☐ Gastrostomy ☐ Exchange ☐ Removal
- ☐ TIPS Consult
- ☐ Liver Cancer Consult

Biopsy
- ☐ Axillary ☐ Left ☐ Right
- ☐ Breast Ultrasound Guided ☐ Left ☐ Right
- ☐ Breast Stereotactic ☐ Left ☐ Right
- ☐ Breast Cyst Aspiration ☐ Left ☐ Right
w/core if necessary
- ☐ Kidney ☐ Left ☐ Right
- ☐ Bone Lesion
- ☐ Liver
- ☐ Other _____

IV Access
☐ PICC Line
- ☐ Placement ☐ Exchange ☐ Removal

☐ Port-a-Cath PT/PTT/INR/CBC/BMP W/30 DAYS
- ☐ Placement ☐ Exchange ☐ Removal

☐ *Permcath
- ☐ Placement ☐ Exchange ☐ Removal

*Labs needed if on Coumadin/Eliquis/Xarelto
PT/PTT/INR/CBC/BMP W/30 DAYS

Drainage
- ☐ *Paracentesis
- ☐ *Thoracentesis

*Labs needed if on Coumadin/Eliquis/Xarelto
PT/PTT/INR/CBC/BMP W/30 DAYS
- ☐ Other (seroma, hematoma, etc.)_____

Genital Urinary
- ☐ Nephrostomy ☐ Placement ☐ Exchange
- ☐ Nephrostogram
- ☐ Nephroureteral / Ureteral Stent

Provider Signature_____ **Date**_____

*** Please include demographics, notes, imaging reports, recent labs, medication list, and insurance card ***

VASCULAR & INTERVENTIONAL HEMODIALYSIS MAINTENANCE

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Patient Information

Patient Name:	DOB:	Appt Date:
Phone:	Alt. Phone:	Appt Time:
Patient Address:		
Insurance Primary:	ID:	

Provider Information

Provider:	Referral Coordinator:	
Referral Coordinator:	Phone:	
Dialysis Clinic:	Phone:	Fax:
Diagnosis (ICD-10)	**Authorization #**	

*** Please include demographics, notes, recent labs, medication list, and insurance card ***

Dialysis Clinic Site_____

Dialysis Clinic Contact_____

Hemodialysis Access Maintenance

☐ **Vein Mapping**
Specify Site:_____

☐ **Ultrasound Evaluation of Existing Bypass**

☐ **Fistula Graft Declot**
Fistula Occluded ☐ **Yes** ☐ **No**

***If fistula is pulling clots or has decreased blood flow during dialysis please order a Fistulagram**

☐ **Fistulagram** ☐ **Yes** ☐ **No**

Required Information for a Fistulagram

Pulling Clots	☐ **Yes**	☐ **No**
Thrill / Bruit	☐ **Yes**	☐ **No**
Low Flow	☐ **Yes**	☐ **No**

☐ **Fistulagram for Access Evaluation / Check**

IV Access

☐ ****Permcath** ****Labs needed if on Coumadin/Eliquis/Xarelto**
☐ Placement ☐ Exchange ☐ Removal
****PT/PTT/INR/CBC/BMP W/30 DAYS**

Complete Labs at Valley Radiology ☐ **YES** ☐ **No**
☐ PT ☐ PTT ☐ INR ☐ CBC ☐ BMP

For Stat Labs, PLEASE send to:
CFVH Diagnostic Center
524 Beaumont Rd.
Fayetteville, NC 28304 (Behind CVS off Owen Drive)
Ph: (910) 615-4845 Fax: (910) 615-7297

Vascular & Interventional Referrals
(See Vascular/Interventional Referral Form)

Provider Signature_____ **Date:_____**