VASCULAR HEALTH INSTITUTE

PATIENT REFERRAL FORM

Patient Information

Patient Name

Date

Patient Phone #

Referring Physician Name

DOB

Referring Physician Phone #

☐ M ☐ F

Gender

Referring Physician Signature

REASON FOR REFERRAL

☐ Leg Pain (PAD)

Indication (please select all that apply)	ICD-10
☐ Peripheral Vascuar Disease	I73.9
☐ Pain in Right Leg	M79.604
☐ Pain in Left Leg	M79.605
☐ Pain in Right Foot	M79.671
☐ Pain in Left Foot	M79.672
☐ Type 2 Diabetes with Peripheral Angiopathy, without gangrene	E11.51
☐ Other (Specify)	

☐ Spine Fracture/Back Pain (Kyphoplasty)

Indication (please select all that apply)	ICD-10
☐ Compression Fracture Thoracic Spine	S22.000A
☐ Compression Fracture Lumbar Spine	S32.000A
☐ Low Back pain	M54.5
☐ Other (Specify)	

☐ Pelvic Pain (Pelvic Congestion/ Varicocele)

Indication (please select all that apply)	ICD-10
☐ Chronic Pelvic Pain - Female	R10.2
☐ Pelvic Varices	I86.2
☐ Other (Specify)	

VASCULAR HEALTH INSTITUTE

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