Vascular Lab Outpatient Order Form

1	EXAM INFORMATION	EXAM LOCATION

M T W TH F

Date: _____

Check in Time: _____

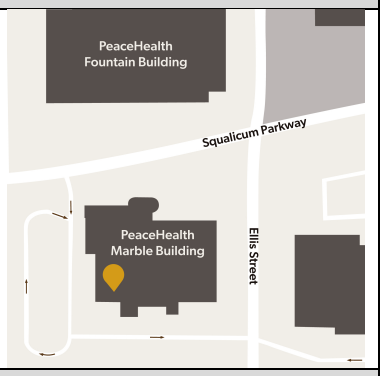
Exam Time: _____

❑ **STAT (same day)**

Phone number **(required)**: _____

❑ **ASAP (within 1-2 days)**

PeaceHealth St. Joseph Medical Center
Outpatient Cardiovascular Imaging
2980 Squalicum Parkway
Suite 219
Bellingham, WA 98225
Scheduling Phone: 360-788-6068
Fax 360-543-9179



2 PATIENT INFORMATION – ***Please Print Clearly***

Name: _____

Phone: _____ Date of Birth: _____/_____/_____

Referred by: _____

Clinical Symptoms/History (required; you must have a sign, symptom or known diagnosis. No "Rule Out" or "Follow-up") _____

ICD-10*: _____

*Indication and ICD-10 are required

3 EXAM ORDERS

Abdominal Exam: (see instructions)

❑ Aorta/Iliac Duplex
❑ Mesenteric Duplex
❑ Renal Duplex
❑ Hepatic/Portal
❑ IVC/Iliac
❑ Aorta Aneurysm Screening
❑ Liver/Kidney Transplant

	BiL	RT	LT
Peripheral Arterial:			
❑ Lower Extremity ABI (ankle/arm index)			
❑ Lower Extremity Arterial Duplex	❑	❑	❑
❑ Upper Extremity Duplex	❑	❑	❑
❑ Hemodialysis Access Graft		❑	❑
Peripheral Venous:			
❑ Lower Extremity Venous (DVT)	❑	❑	❑
❑ Lower Extremity (varicose veins/stasis)	❑	❑	❑
❑ Upper Extremity Venous (DVT)	❑	❑	❑
Cerebrovascular:			
❑ Carotid Duplex	❑		
Other:			
❑ Vein Mapping	❑	❑	❑
❑ Arterial Mapping	❑	❑	❑
❑ Other	❑	❑	❑

ABDOMINAL EXAM INSTRUCTIONS:

1. **FAST** 8 hours prior to exam.
2. **NO** smoking or chewing gum 4 hours prior to exam.
3. **ALL** patients should take a.m. medications with a small amount of water.

PLEASE RETURN FORM TO PATIENT AFTER FAXING TO 360-543-9179

4

Referred by: _____ Date: _____
(Signature)