**Lafayette Vein and Vascular Center**

**Dr. Shoaib Shafique & Kate Dell, DNP**

**3900 St. Francis Way Suite 201**

**Lafayette, IN 47905**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vein Referral:

* Varicose Veins
* Spider Veins
* DVT/ PE/ Phebitis
* Venous ulcer
* Leg swelling
* Pelvic venous disorder
* Other

\*\*\* Is this an urgent request? Yes No

Has patient had previous testing? Yes No

If yes: Testing type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testing location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testing date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax the following:

* + Referral form
	+ Most recent office note
	+ Medication list
	+ Test results (if available)
	+ Demographic
	+ Insurance

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arterial Referral

* Peripheral arterial disease
* Carotid artery stenosis
* Aortic aneurysm
* Renal artery stenosis
* Mesenteric artery stenosis
* New Dialysis Access/Complication