

# ACADEMIC HEART & VASCULAR PLLC

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## VASCULAR TESTING REQUEST

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address/City/St/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Type: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

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

### VASCULAR TESTING IN WOODHAVEN

Carotid Duplex Dx \_\_\_\_\_

Abdominal Aorta Dx \_\_\_\_\_

Lower Extremity Arterial Study DX \_\_\_\_\_  
(ABI, PVR, segmental pressures)

with exercise  without exercise

Reason for visit/comments:

\_\_\_\_\_  
\_\_\_\_\_

Ordering Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

### Requesting office instructions:

- Complete this form with necessary diagnosis
- Call our office to schedule: 734.676.0400
- **Fax a copy of this request form to Academic Heart & Vascular PLLC: 734.676.0404**
- Review preparation instructions on reverse side with patient and give this copy to the patient

HMO Referral Completed? Yes No N/A
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*For AHV office use only:*

Patient contact, date and time:

Patient contact, date and time:

Patient contact, date and time:

Appointment date/time

21090 Allen Road ▪ Woodhaven, Michigan 48183 ▪ (734) 676.0400 phone ▪ (734) 676.0404 fax

Located on the west side of Allen Road just south of King Road – entrance and parking in rear

[www.academicheart.com](http://www.academicheart.com)