



DOCTOR INFORMATION

Referring Practitioner: _____
(Printed)
Address: _____
Tel: _____ Fax: _____
City: _____ Postal Code: _____
Signature: _____ Date: _____

PATIENT INFORMATION

Name: _____
HRN: _____ PHIN: _____
Date of Birth: _____ / _____ / _____
(Day/Month/Year)
Tel: _____

HISTORY

Questions to answer: (Please attach dictated summary)

Allergies: NKA Contrast Other: _____
AntiPlatelet: ASA Pradax Plavix
Other: _____
AntiCoagIn: Xeralto (Rivaroxaban) Coumadin
Eloquis (Apixaban) Other: _____

CARDIOVASCULAR RISK ASSESSMENT

- AAA Screen Carotid Arteries Lower Extremity Arteries / Claudication
 Abdominal & Pelvic Arteries Renal Arteries Upper Extremity Arteries / Raynaud's

ENDOASCULAR THERAPY

ARTERIAL:

- Claudication or Ischemia
 Aneurysm AAA Pelvic Visceral
 Hypertension Renal
 Carotid TIA or CVA
 Embolizations Uterine Fibroids Visceral
 Other: _____

VENOUS:

- DVT Reflux
 Varicose Veins Spider Veins EVLT
 Gonadal Veins Varicoceles
 IVC Filter Insertion
 Thrombolysis
Other: _____

INTERVENTIONAL:

- Tissue Biopsy
Organ: _____
 Vertebroplasty
 Other: _____

VIT USE ONLY

- Laboratory Data: INR PTT Platelets CRP
 Cr 2 Weeks Prior
 Day of None Required
 Moderate Sedation: Yes No
 VIT Recovery Bed: Yes No
 Ancillary Test: US CT MR BS-SPECT
 US Doppler CTA MRA
 VIT Consult: Yes No
 VIT RAD: CG DS MB NL MS RM KM

VIT ANTIPLAT/COAG DIRECTIVES (TIME TO STOP)

VIT Coding: ① ② ③ ④

Medication:	Major	Minor
Warfarin or Pradaxa	5 Days	5 Days
Plavix (Save Angio-none)	5 Days	5 Days
LMWH or Fragmin	6 Hours	6 Hours
Eloquis (Apixaban)	2 Days	None
Xeralto (Rivaroxaban)	1 Day	1 Day
Other: _____		

Time of appointment: _____ **Date of appointment:** _____