VASCULAR AND INTERVENTIONAL RADIOLOGY SERVICES

SCHEDULING
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RAYUS VASCULAR CARE™

Scan the QR Code for location information.

PATIENT INFORMATION	Patient DOB	Sex assigned at birth ○ M ○ F
Patient name (as shown on insurance card)	Primary phone #	Secondary phone #

INSURANCE INFORMATION - Please bring all insurance information to appointment.

Insurance name	Insurance ID #	Group #	Member #

Pre-authorization/Pre-certification #

○ No pre-authorization/Pre-certification required

Other

(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

CONSULT FOR

- ○ Peripheral artery disease (PAD) or Critical limb ischemia (CLI)
- ○ Claudication
- ○ Venous disease
- ○ Varicose veins
- ○ Leg swelling
- ○ Non-healing lower extremity wound
- ○ Uterine fibroids (UFE)
- ○ Pelvic venous congestion syndrome
- ○ Varicocele
- ○ IVC filter placement
- ○ Chest port
- ○ Dialysis fistula maintenance
- ○ Venous access
- ○ GAE (Genicular Artery Embolization)
- ○ Other _____

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DIAGNOSTIC TESTING

○ **As determined by the vascular provider**

○ ABI with exercise	
○ ABI without exercise	
○ Venous ultrasound insufficiency study	○ L ○ R ○ BIL
○ Arterial ultrasound	○ L ○ R ○ BIL
○ Carotid ultrasound	○ L ○ R ○ BIL
○ Thoracic outlet ultrasound	○ L ○ R ○ BIL

REFERRING PROVIDER INFORMATION

Provider name (print)	Provider location City/Zip	Phone #
Provider signature (required) Do not use rubber stamp.	**NPI # (required for new providers)**	Date