Michael Miller, MD—Vascular Surgeon
1930 AL Highway 157
Cullman, AL 35058
Phone: (256) 734-7850 **FAX: (256) 734-9633**

VASCULAR SURGEON REFERRAL FORM

Patient's Name: ____

DOB:______________________Phone#:_________________________________ Cell#:_______________________

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Insurance Carrier: ____

Policy #: ____

Referral authorization # if required ___________________________

Please include clinical documentation such as imaging, lab work, clinic notes, if available.

TESTS REQUESTED (CIRCLE ONE)

Carotid Ultrasound

Abdominal Aortic Screening Ultrasound

UltrasoundEVAR Ultrasound

Peripheral Arterial Ultrasound

Venous

DIAGNOSIS / INDICATIONS (CIRCLE ALL THAT APPLY)

Leg Pain / Claudication

VeinsAbdominal Aortic Aneurysm

Mesenteric Artery Stenosis

Leg Swelling

Carotid Artery Stenosis

Non-healing wound

Varicose / Spider

Renal Artery Stenosis

TIA/Stroke

Other:_______________________________________

Contrast Allergy: (circle one) YES NO

Other Allergies: ________________________________

ORDERING PROVIDER

Physician: ____

Phone #:____ Fax #: ______________________________________

Physician Signature: ____

Appointment Date/Time:_______________________Patient notified on: _____________________

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

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Rev. 10/2021