Buffalo Vascular Care

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Buffalo Vascular Care (Main Office)
6337 Transit Road, Depew, NY 14043

Satellite Offices
190 Washington Avenue, Batavia, NY 14020
6934 Williams Road, Ste 400, Niagara Falls, NY 14304

Referral Form

Referring Physician: _____ Referral Date: _____

***** If you would like to order a consultation and a study, please make one selection in each column*****

CONSULTATION REFERRAL:

Vascular:

_____ Arterial: Claudication _____ Ulcer _____
_____ Renal Artery Stenosis
_____ Mesenteric Ischemia
_____ Venous: DVT_____ Varicose Veins_____ Ulcer_____
_____ AV Access Management: _____
_____ Other: _____

Nonvascular:

_____ Mediport and Venous Access: _____
_____ Kyphoplasty

Women's Health:

_____ Pelvic Congestion Syndrome
_____ Uterine Fibroids
_____ Adenomyosis

VASCULAR LAB STUDY-SELECT DIAGNOSIS BELOW IF ORDERING:

_____ **ABI/TBI**
_____ **Arterial Duplex, specify which leg: _____**
_____ I73.9 Peripheral vascular disease
_____ E11.59 Diabetic w/ Circulation Complications
_____ I70.212 Claudication Left Leg
_____ I70.211 Claudication Right Leg
_____ I70.239 Atherosclerosis of Right Leg w/ Ulcer of Unsp Site
_____ I70.249 Atherosclerosis of Left Leg w/ Ulcer of Unsp Site
_____ **Venous Insufficiency Study**
_____ I87.2 Venous Insufficiency ____Right ____Left
_____ I83.891 Varicose Veins Leg w/ Complications____Right ____Left
_____ **Venous Doppler for DVT**
_____ I82.491 Acute DVT Right Leg
_____ I82.492 Acute DVT Left Leg
_____ Other: _____

Patient Information:

First Name: _____ Last Name: _____

Address: _____
Street City State Zip Code

Phone: _____ DOB: _____/_____/_____ Gender: _____

Please fax the following documents with your referral:

- ✓ **Copy of Patient's Current Insurance Card and Driver's License**
- ✓ **Last Office Note, Test Results, Labs/X-rays**

ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION VASCULAR TESTING

ACCREDITED IASF SURGERY FACILITY