Buffalo Vascular Care

Azher Iqbal, MD
Blanka Heary, RPA-C
Heidi Campbell, RPA-C

p: 716.852.1977
f: 716.852.1959
buffalovascularcare.com

Buffalo Vascular Care (Main Office)
6337 Transit Road
Lancaster, NY 14086

United Memorial Medical Center
229 Summit Street, Suite 8
Batavia, NY 14020

Patient Referal 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____

____ Other: _____

Nonvascular:

____ AV Access Management: _____

____ Mediport and Venous Access: _____

____ Kyphoplasty

Women's Health:

____ Pelvic Congestion Syndrome

____ Uterine Fibroids

VASCULAR LAB STUDY:

____ ABI/TBI

____ Arterial Duplex, specify which leg: _____

____ Venous Doppler, specify which leg: _____

____ Venous Insufficiency Study, Bilateral

SELECT DIAGNOSIS IF ORDERING VASCULAR LAB STUDY:

____ E11.59 Diabetic w/ Circulation Complications

____ I70.212 Claudication Left Leg

____ I70.211 Claudication Right Leg

____ I70.239 Atherosclerosis of Right Leg with Ulceration of Unspecified Site

____ I70.249 Atherosclerosis of Left Leg with Ulceration of Unspecified Site

____ I83.891 Varicose Veins of Right Leg w/ Complications

____ I83.891 Varicose Veins of Left Leg w/ Complications

____ 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

ASF