



New Vein & Vascular Consult Form

F (480)396-1571
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What is PAD? Peripheral arterial disease – also known as PAD – is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brains, or kidneys, become narrowed or clogged. PAD affects over 18 million Americans, most over the age of 50.

Patient Information

Name: _____	DOB MM/DD/YYYY: _____
Phone: _____	Authorization # (if required): _____
Diagnosis (Required): _____	

Preferred Location

- 6309 E Baywood Ave, Ste 101, Mesa, AZ 85206
 3367 S Mercy Rd, Ste 201, Gilbert, AZ 85297
 4838 E Baseline Rd, Ste 105, Mesa, AZ 85206
 37200 N Gantzel Rd, Ste 350, Queen Creek, AZ 85140

Requested Physician

Alphonse M. Ambrosia, DO
 Amy E. Daliman, DO
 Santosh Desai, DO
 No Preference

DO I NEED TO TEST FOR PAD?

People with PAD are at significantly increased risk for stroke and heart attack.

Please circle YES or NO on the questionnaire below to help us determine if you are at risk.

YES NO	Do you experience any pain at rest in your lower leg(s) or feet?
YES NO	Do you have foot, calf, buttock, hip, or thigh discomfort (Aching, fatigue, tingling, cramping, or pain) when you walk, which is relieved by rest?
YES NO	Are your toes or feet pale, discolored, or bluish?
YES NO	Do you have an infection, skin wound, or ulcer on your feet or toes that are slow to heal (8-12 weeks)?
YES NO	Do you have high cholesterol levels, or other blood lipid problems, or do you take medication to lower cholesterol?
YES NO	Do you have high blood pressure or take medication for high blood pressure? YES NO Do you have diabetes?
YES NO	Have you ever smoked?
YES NO	Have you previously had a stroke?
YES NO	Do you have heart disease?

If you answered YES to 1 or more of these questions you may be at risk for PAD and need a vascular consult

Referring Provider Information

Physician/Provider: _____	Contact Person: _____
Phone: _____ Fax: _____	Physician Signature: _____

***PLEASE ATTACH THE FOLLOWING* (Incase authorization from insurance is needed)**

<input type="checkbox"/> Patient Demographics	<input type="checkbox"/> Copy of Insurance Card	<input type="checkbox"/> Blood Work & EKG	<input type="checkbox"/> Insurance Referral
<input type="checkbox"/> Progress Note <input type="checkbox"/> Written Physician Order/Signed RX (if not sending this form)			