Baird Vascular Institute

VCU Health™

Date: ____ / ____ / _____

Patient Name: _____

MR#: _____ DOB: ____ / ____ / _____ Age: ___

Height: ____ft ____in Weight: _____lbs Gender: M☐ F☐

# Referral and Order Form

***Insurance Information***

Insurance Name: _____

PreAuth#_____

Bill Insurance? ☐ Y ☐ N

Diagnosis Code (ICD 9) _____

Reason for study (please print): _____

Indication (please print): _____

## Requested Study

Exam/Procedure Requested: _____

Additional Information: _____

## Patient Medical History

Symptoms: _____ Duration of Symptoms: _____

Prior Surgeries? ☐ Yes ☐ NO If Yes, please describe with dates and locations: _____

_____

Labwork

Completed _____ CR _____ PLT _____ PT _____ INR _____ Bili _____ Hgb Date Completed: _____

Needed _____ CR _____ PLT _____ PT _____ INR _____ Bili _____ Hgb

## Signed Order Required for Scheduling

Referring Physician Name: _____

Referring Physician Signature: _____

Referral Contact Name: _____ Phone# (____) ____ - _____ Fax# (____) ____ - _____

## BVI Use Only

Appt Date: ____ / ____ / _____ Time: ____:_____ ☐AM ☐PM Room: _____ Visit # _____

Sedation?: ☐ Yes ☐ No