WACO CARDIOLOGY ASSOCIATES
7125 Sanger Road, Suite A.
Waco, TX 76712
Phone: 254-399-5484

WOUND CARE CLINIC TESTING REFERRAL
Please fax this completed form to 254-399-5454

DATE:_____

Patient Name(FML)_____

Address_____

Birth Date_____ SS#_____

Home Phone_____ Work Phone_____

Race: _____ Hispanic/Latino: Y N Preferred Language _____

Primary Insurance	Secondary Insurance
_____ Company Name	_____ Company Name
_____ Address	_____ Address
_____ Company Phone #	_____ Company Phone #
_____ Insured Name / Insured ID # / DOB	_____ Insured Name / Insured ID # / DOB

Referring Doctor / NPI # / Contact Name / Phone #_____

Primary Care Provider if different than above_____

Appointment Date_____ Time_____

ECHOCARDIOGRAPHY

[ ] Transthoracic Echocardiogram
[ ] Complete (2D / Doppler) [ ] Limited

Reason(s) for Test: (Diagnosis code)_____

Physician Consult
[ ] Venous
[ ] Arterial

ARTERIAL
[ ] Upper Extremity R L Bilateral
[ ] Lower Extremity R L Bilateral
(Lower Extremity includes: common femoral, superficial femoral, popliteal, anterior tibial, posterior tibial and peroneal)
[ ] Iliacs R L Bilateral
(Iliacs include: aorta, common and external iliacs)

PVR – Arterial Flow Testing *(includes Dopplers, segmental systolic pressures and segmental PVR waveforms)* Patients will be exercised unless otherwise specified.
[ ] Upper Extremity
[ ] Lower Extremity

VENOUS
[ ] Upper Extremity R L Bilateral DVT/Insufficiency
[ ] Lower Extremity R L Bilateral DVT/Insufficiency

Reason(s) for Test: (Diagnosis code) _____

Provider Signature:_____ Date: _____

Please fax front/back of insurance card. If recent surgery (eg, fem-pop, fem-fem, fem-faraway, etc) please fax operative report also.

03/2017 kdd