NCVC
NORTH CAROLINA VASCULAR CENTER

PATIENT REFERRAL FORM

Please fax to (984) 989-6021

Patient Name: _____DOB_____

☐Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home)_____(Cell)_____

Referring Physician:_____ Practice Name: _____

Referring Physician Phone Number: _____Fax: _____

Referral Contact: _____

DX: _____-_____ Insurance: _____ Secondary Ins (if applicable) _____

Ins. Auth. & Expiration Date: _____ : _____

Please Select Provider:

☐ First Available

☐ George Adams, MD ☐ Matthew Hook, MD ☐ Robert "Bobby" Mendes, MD

☐ Mohit Pasi, MD ☐ Ravish Sachar, MD

Please Select Reason for Referral:

☐ Peripheral Artery Disease
☐ Claudication
☐ Critical Limb Ischemia
☐ Wound
☐ Carotid Artery Disease
☐ Venous Disease

If Other than above, please specify: _____

Please select imaging already performed:

☐ Lower Extremity Angiogram (☐Right ☐Left ☐Bilateral)

☐ Lower Extremity Venous Angiogram (☐ Left ☐ Right ☐ Bilateral)

☐ Upper Extremity Arterial Angiogram (☐ Left ☐ Right ☐ Bilateral)

☐ Upper Extremity Venous Angiogram (☐ Left ☐ Right ☐ Bilateral)

☐ ABI

☐ Carotid Angiogram

☐ Duplex

☐ Other _____

Please fax office note with referral to (984) 989-6021. If the patient has already had imaging done, please fax or have patient bring imaging results with them to appointment.

North Carolina Vascular Center
920 South Lombard Street, Ste 200
Clayton, NC 27520

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