NORWEST
SPECIALIST
VASCULAR SERVICES

REFERRAL REQUEST FORM

Patient's Surname: ..... First Name: .....

Patient Address: .....

DOB: ..... Contact Phone Number: .....

☐ **Dr Tom Daly**
FRACS, DDU
Vascular Surgeon

☐ **A/Prof Irwin Mohan**
MBBS, MD, FRCS, FEBVS, FRACS
Vascular Surgeon

☐ **Dr Mauro Vicaretti**
PhD, FRACS
Vascular Surgeon

ARTERIAL STUDIES

- ☐ Carotid study
- ☐ Peripheral arterial leg
- ☐ Peripheral arterial arm
- ☐ Coeliac/ Mesenteric arterial
- ☐ Renal arterial scan
- ☐ Aorto-iliac scan (aneurysm / occlusive disease)
- ☐ Request for Fistula planning and surveillance

PRESSURE STUDIES

- ☐ ABIs (resting)
- ☐ ABI (exercise)
- ☐ Toe Pressures
- ☐ Other

VENOUS STUDIES

- ☐ DVT scan lower leg
- ☐ DVT scan upper limb / head and neck
- ☐ Pelvic vein incompetence
- ☐ Venous incompetence
- ☐ Abdo (IVC/Iliac) veins
- ☐ Vein assessment
- ☐ Vein markings

PATIENT HISTORY/ INDICATION FOR SCAN

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Referring Doctor: .....

Contact No.: .....

Provider No.: .....

Signature: .....

Date: .....

Suite G10, Norwest Private Hospital, 9 Norbrik Drive, Bella Vista NSW 2153
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