Patient Name: ___________________________

UCLA Patient ID #: ____________________

Today's Date: ________________________________

CONTACT PERSON NAME: _________________ **PHONE #:**_____________

GONDA (GOLDSCHMIED) VASCULAR CENTER
200 UCLA MEDICAL PLAZA, SUITE 526
DIAGNOSTIC LAB REQUEST

PLEASE FAX TO (310) 794-9603 PRIOR TO SCHEDULING
TEL. (310) 206-6294, option 2

REFERRING ATTENDING: _______________________ **SPECIALTY:** ________________________

PAGER #: _______________ **PHONE #:** _______________ **FAX #:** ______________

Check off test requested and specific indication(s). Indications listed as "other" often not reimbursed by carrier and patient is responsible for paying full amount.

CEREBROVASCULAR TESTS:
Carotid Duplex

______ Bilateral _______ Right ______ Left

Indications: (must indicate side with R, L or B- bilat)

__ carotid stenosis
__ amaurosis
__ TIA motor
__ stroke motor
__ abnormal gait
__ carotid aneurysm
__ carotid bruit

__ carotid occlusion
__ retinal occlusion
__ TIA sensory
__ stroke sensory
__ abnormal coordination
__ subclavian aneurysm

__ carotid insufficiency
__ visual field defect
__ TIA speech
__ stroke speech
__ syncope
__ trauma

__ post TEA follow-up __ right __ left date op: ____________________

__ other (list): ____

Additional comments about pt:

____

PERIPHERAL ARTERIAL

Tests

__ AAI (ankle arm index)

__ segment press/waveforms (__ arm __ leg)

__ digit plethysmography (__ fingers __ toes)

__ exercise AAI

__ arm duplex scan (__ right __ left __ bilat) special instructions: ______________

__ leg duplex scan (__ right __ left __ bilat) special instructions: ______________

__ ** graft duplex full scan (include velocities) site: ________________________________

__ ** graft velocity only site: ________________________________

__ abd duplex specify: ______________________________________

__ penile pressures __ penile duplex scan

__ other (list): ____

Indications:

__ claudication __ rest pain __ ulcer/gangrene-site ________________________

__ failing graft __ embolism __ limb pain

__ aortic aneurysm __ extreme aneurysm __ other peripheral art dis

__ trauma __ hematoma __ erectile dysfunction

__ other (list): ____

specific comments about pt: ____

PERIPHERAL VENOUS

Tests

__ arm duplex scan (__ right __ left __ bilat)

__ leg duplex scan (__ right __ left __ bilat)

__ leg insufficiency duplex scan (__ right __ left __ bilat)

__ vein mapping duplex (__ right arm __ left arm __ right leg __ left leg)

__ abd vein duplex scan specify: ____

__ duplex scan dialysis access

__ other (list): ____

Indications:

__ DVT __ pulm embolus __ postphlebitic

__ phlebitis __ leg pain __ leg swelling

__ edema __ var vein w/ulcer __ var vein w/inflammation

__ leg ulcer (venous) __ trauma vein arm __ trauma vein leg

__ anomaly vasc system __ malfunction AV access

__ other (list): ____

specific comments about pt: ____

**Medicare does not pay for routine surveillance of prosthetic grafts