Joseph Shams, MD

PATIENT REFERRAL INFORMATION

Peripheral Arterial Disease (PAD)

To be completed by referring physician (please print all information)

PATIENT NAME (first and last): ____

PHONE (home): ___________________________ (mobile): __________________________

DATE OF BIRTH: ___________________________ AGE: _________ SEX: ______________

LANGUAGE ACCOMMODATION? ___ YES ___NO Specify: ______________________

REFERRING PROVIDER: ___________________________________ NPI#: _____________

PHYSICIAN SIGNATURE: __________________________________ DATE:_____________

Reason for Evaluation

please check reason/s and circle leg/s

- ☐ Leg Pain when walking R L
- ☐ Leg Pain at rest R L
- ☐ Non-healing Leg/Foot Ulcer R L
- ☐ Venous Ulceration R L
- ☐ Varicose Veins R L
- ☐ Leg Swelling R L

Cardiovascular Risk Factors

please check all that apply

- ☐ DM
- ☐ HTN
- ☐ Dyslipidemia
- ☐ Active/Prior Smoker
- ☐ HX of CAD
- ☐ HX of TIA/CVA
- ☐ CKD
- ☐ Prior DVT
- ☐ Other __________________________

To refer a patient, please fax completed form to: 212.966.2022

Please include patient demographics, H&P, insurance card and any vascular studies which have been performed.

Please make patient aware that he/she will be contacted by Lower Manhattan Endovascular Center to schedule the vascular consultation.

202 Centre Street, 5th Floor, New York, New York 10013
PHONE: 212.966.2020 | FAX: 212.966.2022 | americanendovascular.com

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