

Mid-South Vascular Physicians

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Vascular/Interventional Radiology Request

Last Name: _____ First Name: _____ DOB: _____

Patient Phone: _____ Allergies: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Clinical History/ Reason for Exam: _____

Referring Physician/ Provider: _____ Referring Phys. Signature: _____

Referring Facility: _____ Referring Facility Phone: _____

Today's Date: _____ Request Expiration: _____

Procedures Requested (*write details on line*):

Peripheral Artery Disease/Peripheral Vascular Disease

Evaluate and treat Lower Extremity PAD (Arterial) Evaluate and treat Lower Extremity PVD (Venous)

Evaluate and treat Upper Extremity PAD (Arterial) Evaluate and treat Upper Extremity PVD (Venous)

Renal Arterial Doppler Bilateral Carotid Arterial Doppler Other
Ultrasound: _____

Wound Care

Evaluate and Treat Wound(s) Location of wound(s): _____

Dialysis Access Maintenance

Dialysis Catheter Please circle one: **Removal** **Exchange** **Placement** Side/Location: _____

PICC Catheter Please circle one: **Removal** **Exchange** **Placement** Side/Location: _____ Lumens: **Single/Double**

PORT Catheter Please circle one: **Removal** **Exchange** **Placement** Side/Location: _____

Evaluate and Treat dialysis fistula Side/Location: _____

Evaluate and Treat dialysis graft Side/Location: _____

Peritoneal Dialysis Catheter Removal Side/Location: _____

Peritoneal Catheter Placement Side/Location: _____

Assessment and Creation of Percutaneous AV fistula OR Vein Mapping

Evaluate for Genicular Artery Embolization (GAE)

Evaluate for Plantar Fasciitis Embolization (PFE)

Evaluate for Uterine Artery Embolization (UFE)