VASCULAR DIABETES WOUND CARE

**Omni Vascular and Diabetes Wound Care Center**
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Board Certified in General and Vascular Surgery

# Referral

## VASCULAR DISEASE WORKUP & TREATMENT

Date: _____

Patient Name: _____ DOB: _____
*Last Name* *First Name* *MM/DD/YYYY*

Telephone #: _____ Email: _____

Diagnosis/Comments: _____

_____

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|---|---|
| ◯ **Peripheral Arterial Disease** | ◯ **Carotid Artery Disease** |
| ◯ **Abdominal Aortic Aneurysm** | ◯ **Thoracic Aortic Aneurysm** |
| ◯ **Thoracic Outlet Syndrome, Brachioplexopathy** | ◯ **Hemodialysis Access Creation and Management** |
| ◯ **Chronic Extremity Wound, Diabetic Wound** | ◯ **Venous Insufficiency, Varicose Veins** |

◯ **Other: (Explain)**

Referring Physician Name: _____ _____
*Name* *Signature*

Referring Physician Contact: _____ _____
*Telephone* *Fax*

_____
*Email*