UTAH VASCULAR CLINIC

REQUEST FOR CLINICAL AND INTERVENTIONAL SERVICES

Fax: (801) 262-1533 Scheduling: (801) 281-0027
650 EAST 4500 SOUTH SUITE100, SALT LAKE CITY, UTAH 84107

Patient Name:_____ DOB:_____

Patient's Phone:_____ Referring Physician:_____

Office Phone:_____ Diagnosis/Symptoms:_____

Insurance Carrier(s):_____

○ **GU/GI Catheter Mainenance*** ○ **Venous Access*** ○ **Uterine Fibroids**
*Specify:

○ **PAD** __Peripheral Vascular Disease __Renovascular Disease __Aortic Aneurysm Other:_____

○ **Venous Disease** __Acute DVT __Varicose Veins __Pelvic Congestion __Varicocele Other:_____

○ **Pain Management** __Vertebral Compression Fracture __Spine/Joint Intervention - specify:_____
**Dedicated pain management forms available*

○ **Interventional Cancer Treatment** - specify:_____

Comments:

Is the patient on blood thinners?_____ Date Stopped:_____
Please note that blood thinners must be stopped several days prior to interventional procedures

Check if one applies: Coumadin_____ Heparin_____ Plavix_____ Other_____

PROVIDER SIGNATURE:_____ Date:_____