**UMI Clinic**

Serving Community | Advancing Clinical Education

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# PATIENT REFERRAL FORM

## ---------- Patient Details: ----------

**Patient Last Name:** _____

**Patient First Name**:_____ **Middle Initial:** _____

**Date of Birth:**_____ **Sex**: ▢ **Male** ▢ **Female**

**Medical Record Number:** _____

**Phone Number**:_____ **Email:** _____

## ---------- Exam Details: ----------

- ▢ Head
- ▢ Soft Tissue Neck
- ▢ Chest
- ▢ Breast (Unilateral or Bilateral)
- ▢ Abdomen Complete
- ▢ Abdomen Limited
- ▢ Abdominal Aorta Screening
- ▢ Retroperitoneum (Renal / Aortic Nodes)
- ▢ Retroperitoneum Limited
- ▢ Transplanted Kidney
- ▢ Transvaginal Non-OB
- ▢ Pelvis Non-OB
- ▢ Pelvis Non OB Limited
- ▢ Scrotum
- ▢ Scrotum + Doppler
- ▢ Extremity Non-Vascular
- ▢ Carotid Screening
- ▢ AAA Screening
- ▢ Carotid Doppler / Duplex
- ▢ Carotid Doppler / Duplex Limited
- ▢ Transcranial Doppler / Duplex
- ▢ Transcranial Doppler / Duplex Limited
- ▢ Duplex Scan Lower Extremity Artery
- ▢ Duplex Scan Lower Extremity Artery Limited
- ▢ Duplex Scan Upper Extremity Artery
- ▢ Duplex Scan Upper Extremity Artery Limited
- ▢ Venous Duplex / Extremity Bilateral
- ▢ Venous Duplex / Extremity Unilateral
- ▢ Duplex Scan Limited Study
- ▢ Duplex Scan of Aorta, IVC, Iliac Vasculature
- ▢ Other (specify in Special Instructions)

## ----------Referring Physician----------

Referring Physician / Practitioner Name:_____

Phone #:_____Email_____

Special Instructions:

Clinical Indication(s):