KERN VASCULAR CENTER
4901 Centennial Plaza Way
Phone: (661) 387-8333 Fax: (661) 241-4053

IMAGING REFERRAL

☐ Urgent ☐ Routine

☐ CAROTID ULTRASOUND	☐ VENOUS ULTRASOUND UPPER EXTREMITY _____ RT _____ LT _____ BILAT
☐ ARTERIAL ULTRASOUND UPPER EXTREMITY _____ RT _____ LT _____ BILAT	☐ VENOUS ULTRASOUND LOWER EXTREMITY _____ RT _____ LT _____ BILAT _____ R/O DVT _____ REFLUX STUDY
☐ ARTERIAL ULTRASOUND LOWER EXTREMITY _____ RT _____ LT _____ BILAT	☐ ILIOCAVAL ULTRASOUND (IVC/ILIAC VEINS)
☐ SEGMENTAL PRESSURE STUDY (ABI)	☐ VEIN MAPPING UPPER EXTREMITY (for dialysis creation)
☐ AORTOILIAC ULTRASOUND (AORTA/ILIAC ARTERIES)	☐ VEIN MAPPING LOWER EXTREMITY (for bypass conduit)
☐ MESENTERIC ULTRASOUND	☐ HEMODIALYSIS ACCESS ULTRASOUND _____ RT _____ LT
☐ RENAL ULTRASOUND	

Date: _____ Referring M.D._____

Phone: _____ Fax: _____ Contact: _____

Patient Name: _____ DOB_____

Diagnosis: _____

Primary Insurance_____ Secondary Insurance_____

***Please attach imaging related to the diagnosis, insurance cards, demographics and referring MD progress note/orders.**

Fax: 661-241-4053
Phone: 661-387-8333 option 4