



Good Samaritan Hospital
Vascular Surgery

Dale Buchbinder, M.D., F.A.C.S.
David P. Coll, M.D., F.A.C.S.
Jeffrey E. Kremen, M.D., F.A.C.S.
R. Jeffrey Breslin, M.D., F.A.C.S.

VASCULAR REFERRAL INFORMATION:

Patient Name: _____ DOB: _____

Patient Phone: _____

Insurance Info: _____

*If insurance requires a referral, patient may present the referral at the scheduled appointment or you may fax it directly to our office.

Referring Physician or PCP Information: _____

Clinical indications for referral: _____

Please check all service(s) you are requesting:

- Vascular Consultation**
- Dr. Buchbinder Dr. Coll First Available Physician

VASCULAR TESTING *ICAVL Accredited Vascular Lab

- Carotid Duplex/Subclavian Scan**
- AAA (Aortic Aneurysm) Ultrasound**
- Venous Doppler-Lower Extremity**
- Bilateral Unilateral (Indicate right or left) _____
- Venous Doppler-Upper Extremity**
- Bilateral Unilateral (Indicate right or left) _____
- Arterial Doppler/PVR-Bilateral Lower Extremities**
- With Exercise**
- Arterial Duplex-Lower Extremity**
- Bilateral Unilateral (Indicate right or left) _____
- Arterial Duplex-Upper Extremity**
- Bilateral Unilateral (Indicate right or left) _____
- Renal Artery Ultrasound**
- Mesenteric Artery Ultrasound**
- Temporal Artery Ultrasound**

Good Samaritan Office 443-444-3431	GBMC Office 410-512-8686
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You may obtain more information, request an appointment, or ask questions via our website at www.gbvs.org