Patient scheduling form:
Peripheral Artery Disease

Today's Date ______________________________

Patient Name ______________________________ **Date of Birth** ______________

Patient Address ______________________ **City** ______________ **State** _____ **Zip Code** _______

Patient Phone (Day) ______________________ **Patient Phone (Evening)** ______________________

Peripheral Artery Disease Consultation for:

O **Leg Pain** O **Leg Edema** O **Varicose Veins**

Slow/Non-Healing Wounds (specify location) O **Thigh** O **Calf** O **Ankle** O **Heel/Midfoot** O **Toes**

O **Other (please specify):** ______________________

Referring Clinician Signature (required) ______________________________

Referring Clinician Name (please print) ______________________________

Please complete the following information:

Referred by ______________________ **Phone** ______________ **Fax** ______________

Competent to sign consent? O Yes O No

If No, whom? ______________________ Phone ______________________

If the patient is confused or forgetful, a second signature is REQUIRED ______________________

Some or all of the following may be required to be faxed to our office:

1. Insurance Cards 2. Pt. Demographic Sheet 3. Medication List 4. Most recent H&P

Azura Use Only – Appointment Date/Time ______________________ **Confirmed by** ______________________

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