MakrisMD
VASCULAR CENTER

700 Pasquinelli Drive
Westmont, IL 60559
P 630.323.8690 | **F** 630.323.8657
MakrisMD.com

Angelo Makris, MD

Patient scheduling form

Today's Date _____

Patient Name _____ **Date of Birth** _____

Patient Address _____

Patient Phone (Home) _____ **(Cell)** _____ **(Work)** _____

Referring Physician _____ **Referring Physician's Signature** _____

Referring Physician Phone # _____ **Fax #** _____

MakrisMD Use Only: Appt. Date _____ ***Appt. Time*** _____ ***Confirmed By*** _____

VASCULAR

☐ **Varicose Vein/Venous Insufficiency Consult and Venous Doppler** **Site** _____ **Side:** ☐ **L** ☐ **R** ☐ **Bilateral**
Indications: ○ Skin Discoloration ○ Tired/Achy Legs ○ Leg Pain ○ Swelling ○ Ulcer ○ Other _____
☐ **Venous Doppler** ☐ **r/o DVT** **Side:** ☐ **L** ☐ **R** ☐ **Bilateral** ○ Pain ○ Swelling
☐ **Varicocele** **Indications:** ○ Pain ○ Infertility
☐ **Peripheral Artery Disease/Arteriogram (PAD) Consult and Arterial Doppler** **Site:** _____ **Side:** ☐ **L** ☐ **R** ☐ **Bilateral**
Indications: ○ Claudication ○ Rest Pain ○ Weak/Absent Pulses ○ Open Sore/Ulcer ○ Other _____
☐ **IVC Filter Placement** ☐ **IVC Filter Removal**

CENTRAL VENOUS ACCESS

☐ **Port Placement** ☐ **PICC** ☐ **Single Lumen** ☐ **Double Lumen** **Site:** _____ **Side:** ☐ **L** ☐ **R**
☐ **Port Removal** ☐ **Groshong® Catheter** ☐ **Power Injectable**
Indications: ○ Cancer ○ Infection ○ Other
Diagnosis Code ICD-10 _____

PAIN MANAGEMENT

☐ **Kyphoplasty/Vertebroplasty Consult and Treatment** **Level:** _____ **Indications:** ○ Back Pain ○ Compression Fracture
☐ **Pain Injections**
○ Epidural Injection ○ Caudal Epidural ○ Neuroforaminal Injection ○ Other _____
○ Facet Injection ○ SI Joint Injection ○ Hip Injection ○ Shoulder Injection
Indications/Symptoms: _____

WOMEN'S HEALTH

☐ **Uterine Fibroid Embolization** ☐ **HSG/Fallopian Tube Recanalization** ☐ **Pelvic Congestion Treatment**
Indications: ○ Pain ○ Heavy Menses ○ Bloating ○ Infertility ○ Other _____

BIOPSY/TUBE CHANGE/OTHER

☐ **Liver Biopsy** ☐ **Thyroid Biopsy** ☐ **Lymph Node Biopsy** ☐ **Other** **Indications:** _____
☐ **Tube Change** ☐ **Drainage Tube** ○ Drainage tube type needed _____
☐ **Paracentesis** **Indications:** _____ ☐ **Ascites** ☐ **Other** _____

To schedule, please call or fax this form with a copy of the following:

1. Insurance Cards **2.** Demographic Sheet **3.** Medication List **4.** Recent Lab Tests/Imaging **5.** Recent H&P/Progress Notes