SJVSC South Jersey Vascular Surgery Center

Paracentesis / Thoracentesis

CONSULTATION REQUEST

Patient Name: _____ Today's Date: _____

Patient Address: _____ Patient Phone: _____

Patient Height: _____ Patient Weight: _____ Patient Date of Birth: _____

Procedure: Paracentesis

Reason: _____

Procedure: Thoracentesis

Reason: _____

Clinical Information:

X-Ray contrast allergy: Yes ☐ No ☐ Reaction? _____

Blood Thinners: Yes ☐ No ☐ List Medications _____

Competent to sign consent: Yes ☐ No ☐ If no, whom: _____ Phone: _____

Transportation:

Does patient need transportation for appointment? Yes ☐ No ☐

Ambulatory ☐ Wheelchair ☐ Stretcher ☐

Supportive Diagnostic Testing: CT ☐ MRI ☐ US ☐

please attach final reports for above diagnostic testing

Referring Physician: _____ **Phone:** _____

FAX FORM WITH PATIENT DEMOGRAPHICS, INSURANCE CARDS, CURRENT LABS, MEDICATION LIST, HISTORY AND PHYSICAL TO 856-482-9399 FOR SCHEDULING

South Jersey Vascular Center - 200 Century Parkway, Suite E, Mt. Laurel, NJ 08054 – (P) 856-482-2800 (F) 856-482-9399