Patient Referral

FAX to 817-717-1840

Patient Information

Patient Name: ______________________ Today's Date: ______________

Patient Phone: ______________________ Patient DOB: ______________

Referring Doctor: ______________ Referring Office Phone: ______________

PCP Doctor: ______________ PCP Phone: ______________ PCP Fax: ______________

Patient Symptoms (check all that apply)

- ☐ Leg/Ankle Swelling
- ☐ Leg Pain/Leg Aching
- ☐ Varicose Veins
- ☐ Restless Legs
- ☐ Leg Night Cramps
- ☐ Leg Skin Discoloration
- ☐ Leg Fatigue/Heaviness
- ☐ Bleeding Veins
- ☐ Leg/Ankle Ulcer/Wound
- ☐ Recurrent Cellulitis/Irritation
- ☐ Other: ______________________

Diagnosis Codes: ______________________________

Suspect DVT

If you suspect a DVT please fill out this section and tell us the symptoms/diagnosis codes.

☐ LEFT Leg ☐ RIGHT Leg ☐ BOTH Legs ☐ Other: ______________

VIP We need symptom/diagnosis codes: ______________________
"Rule out DVT" doesn't count. We need actual symptom or diagnosis. Thank you :)

Special Instructions/Other Concerns for Atlas: ______________________

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Please include patient demographics, insurance information, and medication list whenever possible. Thank you! And Please **FAX to 817-717-1840**

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