Patient Referral

FAX to 833-973-4122

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: _____

_____

_____

Please include patient demographics, insurance information, and medication list whenever possible. Thank you! And Please **FAX to 833-973-4122**

Atlas Vein Care
2701 Matlock Road, Suite 103
Arlington, TX 76015

www.atlasvein.com