VASCULAR & WOUND REFERRAL FORM

FOR REFERRALS: PLEASE CALL OFFICE OR FAX THIS FORM

PHONE: (559) 713-6478 FAX: (559) 409-2124

Referring Physician: ______________________________

Phone: (   ) ____________________ Fax: (   ) ____________________

PCP (if different from referring) ______________________________

Patient Name: ______________________________ DOB: ____/____/____

PATIENT PHONE | INSURANCE

Home: (   ) ____________________ Primary ____________________

Mobile: (   ) ____________________ Secondary ____________________

PATIENT SYMPTOMS

- ☐ DIABETIC FOOT ULCER
- ☐ LEG ULCER
- ☐ LEG DISCOMFORT
- ☐ VARICOSE VEINS
- ☐ LEG SWELLING / LYMPHEDEMA
- ☐ DVT / PHLEBITIS
- ☐ OTHER ____________________

PATIENT HISTORY / PRIOR STUDIES

R	L	
☐	☐	ABI DATE: ____/____/____
☐	☐	ULTRASOUND, LOWER EXTREMITIES DATE: ____/____/____
☐	☐	CTA STUDIES DATE: ____/____/____

P: 559.713.6478 | F: 559.409.2124
Offices: 4050 S. Demaree, Visalia, Ca 93277 | 567 W Putnam, Porterville, Ca 93257