SEQUOIA
VEIN & WOUND

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: ____/____/____