ALEMAN VEIN CENTER

FAX REFERRAL FORM

PLEASE RETURN BY FAX TO (833) 471-4352

FOR SAME-DAY DVT RULE OUT OR URGENT REFERRALS, PLEASE CALL (404) 777-1728

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Preferred Phone Number: _____

Insurance: _____ ID Number: _____

**It would be helpful and save time for your patient to include this insurance info so that our staff may verify benefits for the patient prior to arriving in our office.*

REFERRING PROVIDER INFORMATION

Provider Name: _____ Practice: _____

Phone Number: _____ Fax Number: _____

Reason for referral (*check all that apply*):

*** CALL FOR SAME-DAY DVT RULE OUT ***

- ☐ Varicose veins
- ☐ Leg swelling
- ☐ Leg pain, heaviness, or leg cramping
- ☐ Leg discoloration/hyperpigmentation
- ☐ Venous stasis dermatitis or rash
- ☐ Leg Ulcer
- ☐ Spider veins
- ☐ Second Opinion
- ☐ Other: _____

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