PATIENT REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME: _____	PATIENT DOB: _____
CONTACT #: _____	ALTERNATE #: _____
INSURANCE: _____	ID #: _____ GROUP #: _____

REFERRING PROVIDER INFORMATION

PROVIDER NAME: _____

CONTACT #: _____	CLINIC NAME:_____

VASCULAR IMAGING / VEIN CENTER

PERIPHERAL ARTERIAL

☐ ABI (Ankle-Brachial Index), resting
☐ TBI (Toe-Brachial Index)

PERIPHERAL VENOUS TESTING

☐ Lower Extremity Venous Duplex (Venous Insufficiency Evaluation)
☐ Lower Extremity Venous Duplex – DVT, Bilateral
☐ Lower Extremity Venous Duplex – DVT, Unilateral, RIGHT
☐ Lower Extremity Venous Duplex – DVT, Unilateral, LEFT

PRIORITY

☐ Routine
☐ STAT

INDICATIONS / DIAGNOSES

☐ Skin Ulcer (new, recurrent, or chronic non-healing)
☐ History of DVT
☐ Known Post-Thrombotic Syndrome
☐ Recurrent Cellulitis
☐ Lymphedema
☐ Unexplained Leg Heaviness
☐ Restless Leg Syndrome
☐ Unexplained Leg Cramping
☐ Varicose Veins
☐ Unexplained Leg Pain
☐ Unexplained Numbness
☐ Skin Problems (discoloration, redness, rash)
☐ Other Dx: _____

REFERRING PROVIDER PRINTED NAME: **DATE:**

REFERRING PROVIDER SIGNATURE:

Submit Referral Online OR Fax referral to 512-677-7780 OR Email refferal to Info@LoneStarVein.com

LONE STAR
VEIN CLINIC

Lake Aire Medical Center
2411 Williams Drive
Suite 100
Georgetown, TX 78628
Phone/Fax: (512)677-7780