PATIENT REFERRAL FORM

Patient's Name ________________________ **Date** ____ / ____ / ____

Referring Physician ________________________

Phone ____ / __________ **Fax** ____ / __________

WHEN FAXING TO THE OFFICE PLEASE MAKE SURE TO INCLUDE THE PATIENT DEMOGRAPHICS, INSURANCE INFORMATION AND RECENT NOTES.

CONSULTATION

- ◯ P.A.D. (Peripheral Arterial Disease)
- ◯ Venous Disease / Varicose Veins
- ◯ Uterine Fibroid Embolization
- ◯ Dialysis Access Management
- ◯ Vascular Surgery Clearance
- ◯ Kyphoplasty
- ◯ Other ______________

DIAGNOSTIC ULTRASOUNDS

- ◯ Lower Extremity A.B.I / P.V.R.
- ◯ Lower Extremity Arterial Ultrasound
- ◯ Lower Extremity Venous Ultrasound
- ◯ Dialysis Access Ultrasound
- ◯ Other ______________

ADDITIONAL COMMENTS / REQUESTS

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Referring Physician Signature ______________________________

BROWARD
3109 Stirling Road #100
Fort Lauderdale, FL 33312

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(954) 678-1703 Fax

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400 W 41st St #310
Miami Beach, FL 33140

(305) 763-8734 Office
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CORAL GABLES
2601 SW 37th Avenue #704
Coral Gables, FL 33133

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