PALM VASCULAR CENTERS
STUART · FLORIDA

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
- ◯ Dialysis Access Management
- ◯ Vascular Surgery Clearance
- ◯ Chest Port Placement / Removal
- ◯ 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 ______________________

STUART
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