HEART CENTER

VEIN CENTER REFERRAL

For scheduling questions call **(256) 801-6643**
Please fax to **(256) 801-6896**

REFERRING PHYSICIAN

Physician Name:_____Telephone:_____

Clinic Contact:_____ Fax:_____

Reason for Appointment or Diagnosis:_____

PATIENT INFORMATION-please include demographic sheet with records

Patient Name:_____ Date of Birth:_____

VEIN CENTER PHYSICIANS

☐ **OFFICE EVALUATION & VENOUS REFLUX SCAN – Bilateral CPT 93970**

Diagnosis:_____

*Venous Reflux study must be ordered if a patient has not had one in the last 12 months.

☐ **FIRST AVAILABLE**

☐ **Rashida A. Abbas, MD** ☐ **James P. McGraw, MD** ☐ **Michael L. Ridner, MD**

REFERRING PHYSICIAN SIGNATURE:_____

FOR OFFICE USE ONLY:

Venous Reflux Appointment Scheduled: Date_____ Time:_____

Physician Appointment made with:_____Date:_____Time_____