VASCULAR & VEIN CENTER

REFERRING PHYSICIAN INFORMATION

Physician Name: _____

Clinic Contact: _____ Phone: _____ Fax: _____

PATIENT INFORMATION – *Please include demographic sheet with these records*

Patient Name: _____ Date of Birth: _____ Phone: _____

VEIN CENTER ORDER

☐ **Schedule Office Evaluation & Venous Reflux Scan – Bilateral *CPT-93970***

☐ R60.0 – Peripheral Edema ☐ M79.606 – Leg Pain

☐ 183.8 – Varicose Veins of lower extremities with other complications

SCHEDULE WITH:

☐ **FIRST AVAILABLE**

☐ Rashida Abbas, MD ☐ Michael L. Ridner, MD

VEIN CENTER ORDER
Please fax to 256.801.6896
For scheduling questions, call
256.801.6643

VASCULAR CENTER ORDER

☐ **Schedule Office Evaluation** ☐ **ABIs – Bilateral – *CPT 93922***

☐ Leg Pain with Activity ☐ Discoloration of Lower Extremities ☐ Claudication

☐ Leg Ulcers / Wounds ☐ Carotid Artery Stenosis ☐ Diabetes w/ circulatory complications

☐ Subclavian Artery Stenosis ☐ Renal Artery Stenosis

SCHEDULE WITH:

☐ **FIRST AVAILABLE**

☐ George Soliman, MD, FACC, FSCAI ☐ Mohammad Thawabi, MD

VASCULAR CENTER ORDER
Please fax to 256.801.6896
For scheduling questions, call
256.801.6788

Physician Signature _____ **Date** _____ **Time** _____

FOR OFFICE USE ONLY:

ABIs Scheduled: Date _____ Time _____

Venous Reflux Appointment Scheduled : Date _____ Time _____

Physician Appointment Made With: _____ Date _____ Time _____