VASCULAR & VEIN CENTER

VEIN CENTER ORDER
Please fax to (256) 801-6896
For Scheduling questions call (256) 801-6643

REFERRING PHYSICIAN INFORMATION

Physician Name: _____

Clinic Contact:_____Phone:_____Fax:_____

PATIENT INFORMATION –please include demographic sheet with 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 extremeties with other complications

□ **FIRST AVAILABLE**

□ Rashida A. Abbas, MD □ Michael L. Ridner, MD

Physician Signature_____Date_____Time_____

FOR OFFICE USE ONLY:

Venous Reflux Appointment Scheduled: Date _____Time:_____

Physician appointment made with: _____Date:_____Time:_____

Updated 03-2018