REFERRAL REQUEST

# Valley Vascular Surgery Associates

1247 E. Alluvial Ave, Ste 101, Fresno CA 93720
Phone: (559) 431-6226 Fax: (559) 440-9005

## Vascular Consult

***Referrals can be made by faxing this form or calling the office.***

**Date**: ______________________________ **Number of Pages**: ___________________________

☐ **Randall Stern, M.D.** ☐ **Leo Fong, M.D.** ☐ **Leigh Ann O'Banion, M.D.**

☐ **Phillip Hinton, M.D.** ☐ **Anne Prentice, M.D.** ☐ **Kamell R. Eckroth-Bernard, M.D.**

☐ **Mia McKnight, NP** ☐ **First Available**

Referring Physician: ______________________ PCP (If different from referring): ___________________

Phone Number: ________________________ Fax Number: _________________________

We are ***not*** accepting any Covered CA plans unless they are **Santé (Pathway X HMO)**

**Patient Demo**

Last Name: ___________________________ First Name: ___________________________ MI: ______

Phone Number: _____________________________ Cell Number: ______________________________

DOB: _____________ SSN: _______________ Insurance: ___________ 2nd Insurance: ______________

Language: English/Spanish Other: ____________________

**Patient Symptoms: (please check all that apply)**

- ☐ Claudication
- ☐ Gangrene
- ☐ Carotid disease % __________________
- ☐ Leg/Foot Wound/Ulcer
- ☐ Aneurysm: size ______________
- ☐ Other

**Patient History:**

- ☐ ABI DATE: ___________________
- ☐ Ultrasound, lower extremity DATE: ___________
- ☐ Duplex scan Date: ___________
- ☐ CT scan DATE: ____________

Comments ____________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Please include the following with your referral for our office to properly process your request.**

1. **Patient Demographics (social security number REQUIRED)**
2. **Patient Insurance Cards (front and back)**
3. **Santé Referral/ Medi-cal referral and authorizations (if applicable)**
4. **If the patient has had any ultrasounds for lower extremities, include the study in the referral, if patient has not had one we will schedule one at our office.**

Physician: ___________________________________

Patient Appointment Date: _______________________ Time: ______________________