

FAX REFERRAL REQUEST

# The Vein Center

At

Valley Vascular Surgical Associates  
Comprehensive Treatment of Venous Disorders

1247 E. Alluvial Ave, Ste 101, Fresno CA 93720

Phone: (559) 431-6226 Fax: (559) 440-9005

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

We accept all Major Insurance plans including government programs

**Medi-cal  
Cal Viva  
Health Net  
LaSalle**

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

### VARICOSE VEINS DX ONLY

Date: \_\_\_\_\_ Number of Pages: \_\_\_\_\_

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

Anne Prentice, M.D.    Phillip Hinton, M.D.    Mia McKnight, NP

First Available

Referring Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

PCP (If different from referring): \_\_\_\_\_

### Patient Demo

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Insurance: \_\_\_\_\_ 2<sup>nd</sup> Insurance: \_\_\_\_\_

Language: English/Spanish Other: \_\_\_\_\_

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

### Patient History:

- R L**
- Varicose veins
  - Spider veins
  - Aching
  - Rest pain
  - Heaviness
  - Fatigue
  - Throbbing
  - Itching
  - Burning

- R L**
- Stasis Dermatitis
  - Phlebitis
  - Restless legs
  - Skin changes
  - Ulcer
  - Gangrene
  - Discoloration
  - Swelling
  - Other

- R L**
- ABI DATE: \_\_\_\_\_
  - DUPLEX: DATE: \_\_\_\_\_
  - Ultrasound, lower extremity 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: \_\_\_\_\_