FAX REFERRAL REQUEST

Central Valley Vein and Wound Center

☐ **VISALIA:** 5448 Ave. De Las Robles | Visalia, CA 93291
☐ **SELMA:** 1850 Floral Ave. | Selma, California 93662
Phone: 559.721.4910 | Fax: 559.721.4920
UniversityMDs.com | CVVeinAndWound.com

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

Date: _____ Number of Pages: _____

Vascular Surgery
☐ Leo Fong, M.D. ☐ Phillip Myers, PA-C, CLS ☐ Josh Day, PA-C MS
☐ *First Available Provider*

Varicose Vein Referral Only: ☐ Needs Immediate Attention ☐ Please Schedule an Appointment

Referring Physician: _____

Phone: _____ Fax: _____

PCP (if different from referring): _____

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Patient Cell: _____

Primary Insurance: _____ Secondary Insurance: _____

Sante Authorization (For wound care management only): _____

Patient Symptoms: (please check all that apply)

R	L		R	L	
☐	☐	Aching	☐	☐	Rest pain
☐	☐	Burning	☐	☐	Restless legs
☐	☐	Discoloration	☐	☐	Skin changes
☐	☐	Fatigue	☐	☐	Concerning veins
☐	☐	Foot pain	☐	☐	Stasis Dermatitis
☐	☐	Gangrene	☐	☐	Swelling
☐	☐	Heaviness	☐	☐	Throbbing
☐	☐	Itching	☐	☐	Toe
☐	☐	Leg pain	☐	☐	Ulcer
☐	☐	Phlebitis	☐	☐	Varicose veins

Patient History:

R	L	
☐	☐	ABI Date: _____
☐	☐	Duplex Date: _____
☐	☐	Compression Stockings
		Duration: _____

Prior Studies

R	L	
☐	☐	Ultrasound, lower extremity

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. **NOTE: AUTHORIZATIONS MUST INCLUDE CODES 99243 AND 93922**
5. 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.

Thank you very much for referring your patient to our office! **Please fax to: 559.721.4920**