Valley Vascular Surgery Associates

In affiliation with UCSF Fresno

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

Date: _____ Number of Pages: _____

- ☐ *First Available Physician*
- ☐ Kamell Eckroth-Bernard, MD
- ☐ Yan Cho, MD, RPVI
- ☐ Leo Fong, MD
- ☐ Philip Hinton, MD
- ☐ Leigh Ann O'Banion, MD, FACS, FSVS, RPVI
- ☐ Anne Prentice, MD, FACS
- ☐ Sammy Siada, DO, RPVI
- ☐ Randall Stern, MD, FACS
- ☐ Robert Baber, PA-C
- ☐ Maria (Mia) McKnight, NP

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	
☐	☐	Aching
☐	☐	Aneurism, Size:_____
☐	☐	Burning
☐	☐	Cartoid Disease
☐	☐	Claudication
☐	☐	Discoloration
☐	☐	Fatigue
☐	☐	Foot pain
☐	☐	Gangrene
☐	☐	Heaviness
☐	☐	Itching
☐	☐	Leg pain

R	L	
☐	☐	Phlebitis
☐	☐	Rest pain
☐	☐	Restless legs
☐	☐	Skin changes
☐	☐	Spider veins
☐	☐	Stasis Dermatitis
☐	☐	Swelling
☐	☐	Throbbing
☐	☐	Toe
☐	☐	Ulcer
☐	☐	Varicose veins

Patient History:

R	L	
☐	☐	ABI Date:_____
☐	☐	Duplex Date:_____

Prior Imaging:

- ☐ ☐ Ultrasound date/faciity:_____
- ☐ ☐ CT date/faciity:_____

Comments: _____

_____

_____

Thank you very much for referring your patient to our office!

09.15.2022