Please fax this completed form to (207) 767-1245.
If you use a HIPAA compliant email platform, you can also email the completed form to avcinfo@advancedveincenter.com

PATIENT INFORMATION

Today's Date (DD/MM/YYYY): _____

First Name: _____ Middle Initial: _____ Last Name: _____

Patient DOB (DD/MM/YYYY): _____ Sex: (Male)_____ (Female)_____

Patient Address: _____

_____

Patient Email: _____ Patient Phone: _____

Insurance Plan :_____

Policy Holder: _____

Member ID: _____ Group #: _____

Appointment (to be completed by AVWC Staff) Date (DD/MM/YY): _____ *Time:*_____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____

Practice Contact (if different from referring physician): _____

Practice Name: _____

Practice Address: _____

_____

Practice Email: _____

Practice Phone: _____ Practice Fax: _____

REFERRAL DETAILS

Please mark appropriate exam type(s), side and/or extremity (if applicable), and indications (if applicable)

(X)	Exam Type	Side and/or extremity & indications (if applicable)
	Rest Pain	
	Phlebitis	
	Acute DVT	
	Dx of DVT	
	Chronic DVT	
	Venous Insufficiency	
	Gangrene Extremity	
	Venous Ulcer	
	Stasis Ulcer	
	Swelling in Limb	
	Pain in Limb	
	Varicose Veins	
	Spider Veins	
	Post-thrombotic Syndrome	
	Other	

Additional notes (if applicable):_____

_____

_____

This form can be downloaded at any time from our website at advancedveincenter.com/physician-resources, or can be provided by Advanced Vein & Wound Center office staff upon request.