# Logo  Description automatically generated

# 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](http://www.advancedveincenter.com/physician-resources/), or can be provided by Advanced Vein & Wound Center office staff upon request.