PATIENT REFERRAL

Patient Information

Patient Name: _____ Today's Date:_____

Patient Phone: _____ Patient's DOB: _____

Referring Physician: _____ Referring Office Phone:_____

Patient Symptoms: (check all that apply)

- ☐ Leg/Ankle Swelling
- ☐ Leg Pain/ Leg Aching
- ☐ Leg Fatigue / Tiredness
- ☐ Leg Heaviness
- ☐ Leg Cramps
- ☐ Bleeding Vein
- ☐ Varicose Veins
- ☐ Leg Discoloration
- ☐ Leg/Ankle Ulcer / Wound
- ☐ Recurrent Cellulitis
- ☐ Spider Veins
- ☐ Other _____

Suspect DVT

☐ Right leg ☐ Left Leg ☐ Both Legs ☐ Other_____

*Please include patient demographics, insurance information and medication list whenever possible and **FAX** to 224-398-8120.

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