northwest vein center

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○ STAT

VASCULAR REFERRAL

Patient Name ______________________________ Date ______________

Date of Birth ____________________ Referring Physician ______________________

Patient Phone ____________________ Physician Signature ______________________

Insurance ____________________ Office Fax ______________________

INDICATIONS

Check all symptoms that apply

- ○ Varicose Veins
- ○ Aching/pain
- ○ Heaviness
- ○ Tiredness/fatigue
- ○ Itching/Burning
- ○ Swelling
- ○ Pelvic pain/congestion
- ○ Vulvar varicose veins
- ○ Spider Veins
- ○ Cramps
- ○ Restless legs
- ○ Throbbing
- ○ Skin changes/ulcer
- ○ Other____________

VASCULAR CONSULTATION

○ Vascular Consult ○ BIL ○ Left ○ Right

ULTRASOUND

○ Lower Extremity Venous ○ BIL ○ Left ○ Right

○ Suspected DVT

○ Pelvic Venous Congestion

**You are being referred to a venous disease specialist.
Please call today to schedule an appointment.**