Vascular Health Center
Comprehensive Vascular Care

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PHYSICIAN CONSULT – PATIENT REFERRAL FORM

PATIENT NAME (Last, First, Middle) _____

DATE OF BIRTH _____ SOCIAL SECURITY#_____

ADDRESS _____ CITY _____STATE _____ ZIP _____

HOME # _____ MOBILE #_____ E-MAIL _____

PREFERRED METHOD OF CONTACT (Circle One): HOME/ MOBILE / EMAIL / OTHER _

REFERRING PROVIDER NAME _____REFERRING PROVDER PHONE # _____

REFERRING PROVIDER FAX # _____PATIENT'S PRIMARY INSURANCE _____

PATIENT'S SECONDARY INSURANCE _____

PLEASE SEND A COPY OF THE PATIENT'S INSURANCE CARD(S), FRONT AND BACK.

DOES PATIENT'S INSURANCE REQUIRE AN AUTHORIZATION? YES / NO (Circle One)

DIAGNOSIS _____

PRIMARY CARE PROVIDER _____

REFER TO FIRST AVAILABLE / ELSHAARAWY / ALAM (Circle One)

URGENT YES / NO (Circle One)

LOCATION BATTLE CREEK / HILLSDALE / STURGIS / COLDWATER (Circle One)

PREVIOUS TESTING YES / NO (Cirle One) **IS TESTING NEEDED PRIOR TO VISIT** YES / NO (Circle One)

WHAT TEST? ULTRASOUND / CT / MRI / X-RAY / EKG / OTHER _____ (Circle One) **PLEASE SEND A COPY OF THE RESULTS**

WHERE _____ DATE _____

ORDERING PROVIDER'S SIGNATURE (REQUIRED) _____

*****PLEASE MAKE SURE TO SEND PATIENT'S MEDICAL RECORDS IF YOU ARE REQUESTING TO SEE A PROVIDER*****

FOR OFFICE USE ONLY

APPPOINTMENT DATE _____ TIME _____
APPPOINTMENT DATE _____ TIME _____
PLEASE NOTIFY PATIENT OF APPOINTMENT / PATIENT CONFIRMED / LEFT VOICEMAIL
STAFF INITIALS _____

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