AVANCÉ
VEIN CARE

PHYSICIAN REFERRAL

Address:
Phone: Fax:
Secure email: NP

PATIENT

Name: DOB: Phone:
Insurance: Member ID: ☐ Card copies a

REFERRING CLINICIAN

Name: Practice:
Phone: Fax: NPI:
Signature: Date:

REASON (check)

☐ Symptomatic varicose veins (pain/heaviness)
☐ Skin changes / ulcer
☐ Suspected venous reflux
☐ Rule out DVT
☐ Leg swelling
☐ Recurrent SVT
☐ Post-DVT care
☐ Other:

REQUEST (check) — DIAGNOSTIC

☐ Venous duplex with reflux mapping — Laterality: ☐ R ☐ L ☐ Both
☐ Venous duplex for DVT rule-out — Laterality: ☐ R ☐ L ☐ Both

(CPT ref: 93971 unilateral, 93970 bilateral — verify payer policy)

PRIOR CARE (optional)

Compression use ☐ Yes ☐ No Duration weeks

CONTACT & URGENCY

By: Phone Email

Urgency: ◉ Routine (2–4 wks) ○ Soon (≤7 days) ○ Urgent (≤72 hrs)

HIPAA

I authorize release of relevant PHI to Avance Vein Care for coordination of care.

Patient/Guardian: Date:

SUBMIT: Fax (___) ___-____ | Secure email _____