FAX REFERRAL REQUEST

# CENTRAL VALLEY VEIN AND WOUND CENTER


☐ **VISALIA:** 1918 S. COURT STREET VISALIA, CA 93277

☐ **CLOVIS:** 3120 WILLOW AVE. #101 CLOVIS, CA 93612

☐ **HANFORD:** 1320 BAILEY DR. #103 HANFORD, CA 93230

☐ **SELMA:** 1850 FLORAL AVENUE SELMA, CA 93662

**PHONE:** (559) 721-4910 **FAX:** (559) 721-4920

**WEBSITE:** CVVEINANDWOUND.COM


**REFERRALS CAN BE MADE BY FAXING THIS FORM OR CALLING THE OFFICE.**

## VASCULAR SURGEON

LEO FONG, M.D.

## VEIN, VASCULAR AND WOUND REFERRAL

☐ Needs Immediate Attention ☐ Please Schedule An Appointment

Referring Physician:_____

Phone:( )_____ Fax:( )_____

PCP if different from referring :_____

Patient Name:_____ DOB:_____ / _____ / _____

Patient Home Phone:( )_____ Patient Mobile:( )_____

Primary Insurance:_____ Secondary Insurance:_____

## PATIENT SYMPTOMS

please check all that apply

| R | L | | R | L | |
|---|---|---|---|---|---|
| [] | [] | Diabetic Foot Ulcer | [] | [] | Rest Pain |
| [] | [] | Burning | [] | [] | Restless Legs |
| [] | [] | Discoloration | [] | [] | Skin Change |
| [] | [] | Fatigue | [] | [] | Concerning Veins |
| [] | [] | Foot Pain | [] | [] | Stasis Dermatitis |
| [] | [] | Gangrene | [] | [] | Swelling |
| [] | [] | Heaviness | [] | [] | Throbbing |
| [] | [] | Itching | [] | [] | Aching |
| [] | [] | Leg Pain | [] | [] | Ulcer |
| [] | [] | Phlebitis | [] | [] | Varicose Veins |

## PATIENT HISTORY

R L

[] [] ABI Date: _____ / _____ / _____

[] [] Duplex Date: _____ / _____ / _____

[] [] Compression Stockings Duration:
_____ [] Days [] Months

## PRIOR STUDIES

R L

[] [] Ultrasound, Lower Extremity

Comments:_____

**Please include the following with your referral for our office to properly process your request.**

1. Patient Demographics (social security number is REQUIRED)
2. Patient Insurance Cards (copy of the front and back of cards)
3. Medi-cal referral and authorizations (if applicable)
4. **NOTE: AUTHORIZATIONS MUST INCLUDE CODES 99243 AND 93922**
5. If the patient has had any ultrasounds for lower extremities, include the study in the referral, if the patient has not had one we will schedule one at our office.

**Thank you very much for referring your patient to our office! PLEASE FAX TO: (559) 721-4920**