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PROVIDER REFERRAL FORM ● FAX TO: 907-222-6870

Patient Name: ________________________________ DOB: ______/______/________

Contact Phone: ______-______-______ DATE OF REFERRAL: ______/______/________

PROVIDER NAME & DEGREE:____

PRACTICE NAME: ____

PRACTICE PHONE: ______-______-________ PRACTICE FAX______-______-________

Referrer Email: ______________________________ @ __________________ . ________

REASON FOR REFERRAL:

- ☐ VARICOSE VEINS OF THE LOWER EXTREMITIES
- ☐ VARICOSE VEINS OF OTHER SITES: ____________________________
- ☐ LYMPHEDEMA
- ☐ LEG SWELLING
- ☐ DEEP VENOUS THROMBOSIS / SUPERFICIAL THROMBOPHLEBITIS
- ☐ OTHER / COMMENTS:

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☐ **Requested Intervention**: evaluation and treatment

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SIGNATURE