MADISON HOSPITAL

VEIN CENTER

FAX TO: (256) 817-5494

Please fill out completely and fax:

- This form
- Copy of front and back of insurance card(s)
- Recent office notes
- Imaging records (if applicable)

Physician Referral Fax Form

Referring physician:

Physician address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

Date of referral _____ Name of person completing form _____

Please schedule with (Check One): ☐ 1st Available ☐ Dr. Knott ☐ Dr. Strickland ☐ Dr. Welborn ☐ Dr. Kiessling

Patient Information Dx:

Patient last name _____ Patient first name _____

Patient address _____ Gender _____ Marital Status _____

City _____ State Zip _____ Date of birth _____

Phone _____ Family Physician _____

Emergency Contact _____ Emergency Contact number _____

Has the patient been seen by another vascula specialist? Yes / No If yes, whom? _____

Has the patient had any previous vascula procedures? Yes / No If yes, when? _____

Insurance

Primary Insurance Co _____ Name of Policy Holder _____

Insurance Co Address _____ SSN _____

Group Number _____ Date of Birth _____

ID Number _____ Insurance Co Phone _____

Secondary Insurance _____ Name of Policy Holder _____

Insurance Co Address _____ SSN _____

Group Number _____ Date of Birth _____

ID Number _____ Insurance Co Phone _____

Workman's Compensation

Were you injured on the job? Yes / No

Date of Accident _____

Workman's Comp Carrier _____

Claim Number _____

Attention to _____

Address _____

City _____

State _____ Zip _____

Phone Number _____

Employer at Time of Accident

Madison Hospital Vein Center
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