MADISON HOSPITAL

VEIN CENTER

FAX TO: (256) 265-5494

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. Ridner ○ 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 _____

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