VEIN SPECIALISTS OF THE SOUTH LLC
COMPREHENSIVE VEIN CARE

Consultation Verification Form

Patient Name:_____ DOB:_____ Sex:_____
Address:_____
Home Phone#:_____ Alternate Phone#:_____

Primary Insurance:_____
Primary Doctor:_____

Referring Provider/NPI#:_____ Telephone#:_____
Referring Practice Name:_____ Fax#:_____

Patient's diagnosis/conditions/signs/symptoms:_____

_____

Please sign, date, and fax back to our office
Attention Melissa Clark, Referral Coordinator

Requesting a Consultation:
Requesting provider is asking for the opinion, advice, recommendation, suggestion, direction, or counsel in evaluating or treating this patient. The requesting provider understands that consulting physician may initiate diagnostic services and treatment at the time of the initial appointment. Requesting provider will receive a written report outlining the consultant's opinion and advice regarding this patient.

To aid us in the evaluation of this patient, please forward the following medical records:

1) Any lab results
2) Any Ultrasounds and Doppler Studies
3) Most recent office notes
4) COPY OF INSURANCE CARDS (FRONT & BACK)

Please keep this document in your chart as a part of you Plan of Care.

Form Completed by:_____
Name (signature) Date

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