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 To: Referrals Dept

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 the 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 your Plan of Care.

Form Completed By:_____
Name (signature) Date

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