JOSEPH TY BELL, M.D.

DAVID G. SMITH, M.D.

PROVIDER REFERRAL FORM

Patient name: ____ **DOB** ____________________

Best Contact # ________________________________ **(Alternate #** _________________________**)**

Referring provider name: ______________________________ **Fax #** _______________________

Practice name (if different): ____

Please check all that are of concern to you regarding your patient:

Affected extremities: ☐ Both legs ☐ Right leg ☐ Left leg

☐ Varicose veins

☐ Unexplained pain and/or swelling

☐ Restless Leg symptoms

☐ Unexplained numbness

☐ Skin problems (including discoloration, redness, rash)

☐ Skin ulcer (either new, recurrent, or chronic non-healing)

☐ History of deep vein thrombosis (DVT)

☐ Known post-thrombotic syndrome (a.k.a. post-phlebitic syndrome)

Other: ____

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PLEASE FAX THIS FORM TO: 866-550-6776

If the provider has questions for our doctors, please reach us at one of #s below:

Juneau 523-1070 | Wasilla 631-3799 | Soldotna 262-1900

Toll-free: 855-907-8346 (VEIN)