Vein Specialists of Alaska

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PROVIDER REFERRAL FORM

Patient Name: _____ **DOB:**_____

Contact #: _____ **Alternate #:** _____

Referring Provider: _____ **Fax #:** _____

Practice Name: _____ **Phone #:**_____

PLEASE CHECK ALL THAT ARE OF CONCERN FOR THIS PATIENT:

LOWER EXTREMITIES AFFECTED: ☐ **BOTH** ☐ **RIGHT** ☐ **LEFT**

- ☐ Varicose Veins
- ☐ Unexplained pain and/or swelling
- ☐ Restless Leg Symptoms
- ☐ 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: _____

PLEASE FAX THIS FORM TO: 1-866-550-6776

PLEASE INCLUDE THE FOLLOWING: DEMOGRAPHICS, INSURANCE CARDS, MEDICATION & ALLERGY LIST, HELPFUL CLINIC NOTES

LOCATION INFORMATION:

WASILLA
2851 E Palmer Wasilla Hwy Ste 4
Wasilla, AK 99654
907-631-3799

SOLDOTNA
34851 Kenai Spur Hwy Ste 7
Soldotna, AK 99669
907-262-1900