VEIN CLINIC
OF KANSAS

PROVIDER REFERRAL FORM

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Patient Information

Name: ________________________ DOB: ________________________
Address: ________________________________ Phone:

Insurance Information

Carrier Name: ________________________________
Policy ID: ________________________ Group ID: ________________________

Reason for Referral

□ Initial Consult
□ Re-Establish Care
□ 24/48 hr Holter Monitor
□ 30 Day Monitor
□ Nuclear Treadmill
□ Lexiscan
□ Stress Echo
□ GXT

□ Tilt Table
□ Echocardiogram
□ Arterial Ultrasound
□ Venous Insufficiency
□ Venous Ultrasound
□ Abdominal Aorta Ultrasound
□ Carotid Ultrasound
□ General Ultrasound(Kidney,Bladder,Renal, Etc)

□ Echo with Bubble Study
□ Pulmonary Rehab
□ Cardiac Rehab
□ Dietitian
□ Wound Care

Diagnosis: ________________________________

Notes: ____

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Referring Provider Name: ________________________ Phone: ____________
Signature: ________________________ Date: ____________

Any tests ordered will need to have a prior authorization done before test will be scheduled. Please include this with the order to avoid delays in scheduling

For Cardiology consults, please send ALL CARDIAC RELATED RECORDS, recent progress notes with complete medication list, and any tests the patient has done such as: Echo, EKG, Stress Test.