REFERRAL REQUEST

CENTRAL VALLEY VEIN AND WOUND CENTER

☐ **VISALIA:** 1918 S. COURT ST. VISALIA, CA 93277
☐ **CLOVIS:** 3120 WILLOW AVE. #101 CLOVIS, CA 93612
☐ **HANFORD:** 1320 BAILEY DR. #103 HANFORD, CA 93230
☐ **SELMA:** 1850 FLORAL AVE. SELMA, CA 93662
☐ **SALINAS:** 505 E. ROMIE LANE, STE I, SALINAS, CA 93901
☐ **STOCKTON:** 1140 W. HAMMER LN. STOCKTON, CA 95209

PHONE: (559) 721-4910 **FAX:** (559) 721-4920 **WEBSITE:** cvveinandwound.com

LEO FONG, M.D.
VASCULAR SURGEON & MEDICAL DIRECTOR

☐ Needs Immediate Attention ☐ Please Schedule An Appointment

Referring Physician: _____

Phone: ( ) _____ Fax: ( ) _____

PCP (if different from referring): _____

Patient Name: _____ DOB: _____

Patient Home Phone: ( ) _____ Patient Mobile: ( ) _____

Primary Insurance: _____ Secondary Insurance: _____

PATIENT SYMPTOMS

Please check all that apply

R	L		R	L	
☐	☐	Diabetic Foot Ulcer	☐	☐	Rest Pain
☐	☐	Burning	☐	☐	Restless Legs
☐	☐	Discoloration	☐	☐	Skin Change
☐	☐	Fatigue	☐	☐	Non-Healing Wound
☐	☐	Foot Pain	☐	☐	Stasis Dermatitis
☐	☐	Gangrene	☐	☐	Swelling
☐	☐	Heaviness	☐	☐	Throbbing
☐	☐	Itching	☐	☐	Aching
☐	☐	Leg Pain	☐	☐	Ulcer
☐	☐	Phlebitis	☐	☐	Pressure Ulcer
☐	☐	Surgical Wound	☐	☐	Venous Leg Ulcer
☐	☐	Varicose Veins			

Comments: _____

PATIENT HISTORY

R	L	
☐	☐	ABI Date: _____
☐	☐	Duplex Date:
☐	☐	Compression Stockings Duration: # ____ ☐ Days ☐ Months

PRIOR STUDIES

R	L	
☐	☐	Ultrasound, Lower Extremity

Please include the following with your referral for our office to properly process your request.

1. Patient Demographics (social security number is required)
2. Patient Insurance Cards (copy of the front and back of cards)
3. Medi-Cal Referral and Authorizations (if applicable)
4. NOTE: AUTHORIZATIONS MUST INCLUDE CODES 99204 AND 99205
5. If the patient has had any ultrasound for lower extremities, include the study in the referral, if the patient has not had one we will schedule one at our office.

Thank you very much for referring your patient to our office! PLEASE FAX TO: (559) 721-4920