PHYSICIAN REFERRAL FORM

4000 Longpoint Way, Suite 440
Franklin, TN 37064

REFERRAL TO: J. Avery Reynolds, MD
PHONE NUMBER: 615-716-VEIN (8346)

TODAYS DATE: _____
FAX NUMBER: 833-450-0812

PATIENT NAME: _____ **PATIENT PHONE:** _____ **DOB:** _____

EVALUATION FOR:

☐ SPIDER VEINS ☐ VARICOSE VEINS

☐ BLEEDING VARICOSE VEINS ☐ RESTLESS LEGS ☐ TIRED/HEAVY/ACHING LEGS

☐ LEG PAIN/TENDERNESS ☐ LEG SWELLING ☐ LEG CRAMPS

☐ DISCOLORED SKIN/RASH ☐ LEG ULCER ☐ PELVIC PAIN

☐ OTHER: _____

PATIENT INSURANCE INFORMATION

PRIMARY	SECONDARY
INSURANCE NAME:	INSURANCE NAME:
POLICY HOLDER:	POLICY HOLDER:
POLICY HOLDER DOB:	POLICY HOLDER DOB:
MEMBER ID:	MEMBER ID:
GROUP #:	GROUP #:

REFERRING PROVIDER:

NAME: NPI:
PHONE NUMBER: FAX NUMBER:

PLEASE ATTACH THE FOLLOWING:

☐ MOST RECENT ENCOUNTER SUMMARY ☐ CURRENT MEDICATION LIST

NOTES:

THANK YOU FOR YOUR INTEREST IN OUR SERVICES. PLEASE FILL OUT THE INFORMATION ABOVE AND FAX TO 833-450-0812.