

ONE VEIN CLINIC

PROVIDER REFERRAL FORM

206 Ashourian Ave, Suite 213, St. Augustine, FL 32092

FAX REFERRALS TO

888-464-0609

Phone 904-990-0777 | Group NPI 1912599515
Mon-Fri, 9:00 AM - 4:30 PM

Please include: insurance card (front and back), recent office notes, and any prior venous ultrasound reports.
We contact the patient to schedule within 1 business day.

PATIENT

Patient name _____ Date of birth _____
Phone _____ Email _____
Insurance _____ Member ID _____

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

- | | |
|---|---|
| ☐ Varicose veins with pain or swelling (I83.81_) | ☐ Chronic venous insufficiency (I87.2) |
| ☐ Lymphedema (I89.0) | ☐ Leg swelling / edema (R60.0) |
| ☐ Venous ulcer / wound (I83.0_, I83.2_) | ☐ Skin discoloration / stasis dermatitis (I87.2, I83.1_) |
| ☐ Leg heaviness / restless legs | ☐ Spider veins (cosmetic) |

Other / additional ICD-10 _____

Leg: ☐ Right ☐ Left ☐ Both

Request: ☐ Evaluate & treat ☐ Ultrasound only

☐ Urgent (open wound or rapidly worsening symptoms)

Clinical notes / symptoms

REFERRING PROVIDER

Provider name _____ NPI _____
Practice _____ Office contact _____
Phone _____ Fax _____
Provider signature _____ Date _____

Treatments offered: Radiofrequency Ablation, VenaSeal, Varithena, Sclerotherapy, in-house venous duplex ultrasound.

FAX TO 888-464-0609 | Questions? Call 904-990-0777