REFERRAL SHEET

Vascular Care of Maine
489 State Street
Bangor, ME. 04401
Phone: (207) 973-6670 Fax: (207) 973-5226

Date of Referral:__________

PLEASE FAX COMPLETED REFERRAL SHEET ALONG WITH: RECENT OFFICE NOTES, LAB AND RADIOLOGY REPORTS, MEDICATION LIST, AND PROBLEM LIST

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: ______________________ Date of birth: __________ Social Security #: _________________

Home phone#: ____________________Work phone#: ____________________Cell#: ____________________

Address:____

Parent/Guardian Name:_________________________________ Phone #'s:___________________________

Previous Testing: CTA/CT ___________ US __________ PVRs/ABIs _____________

*****ANY CTA/CT/US NOT AVAILABLE ON THE PACS SYSTEM MUST BE RECEIVED BY CD FOR REVIEW PRIOR TO APPOINTMENT DATE*****

REFERRAL INFORMATION

Referring Physician:________________________ Contact Name:_____________________ Ext.______

Physician phone#:__________________________ Physician Fax#:_____________________

Reason for Referral (Signs & Symptoms)____

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INSURANCE INFORMATION ***WORKERS COMP. YES NO***

First Insurance____

1st Ins Certification #______________________________Group #__________________

Second Insurance____

2nd Ins Certification #_____________________________Group #__________________

*****MAINECARE AND TRICARE REFERRALS MUST BE SENT WITH THE REFERRAL NOTES*****

****THIS SECTION TO BE COMPLETED BY VASCULAR STAFF ONLY****

Testing Date:________________Time:____________Location:____________________

Appointment Date:________________ Time:___________Provider:________________

*****REFERRING OFFICE IS RESPONSIBLE FOR NOTIFYING PATIENT OF APPOINTMENT DATES AND TIMES*****