CHAMPLAIN VALLEY VASCULAR

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Dear Sir/Madam,
Please complete all sections of this form accurately to ensure we can provide the best possible care for our clients. This form helps us understand your needs and how we can assist you effectively.

Referring Provider/Practice:

Name: ____________________
Emergent: <3 days ☐
Urgent: Up to 2 weeks ☐
Contact Phone: ____________________
Routine: ☐
Primary Care Provider: ____________________
Referral Date: ____________________

Patient Details:

Patient Name: ____________________
Date of Birth: ____________________
Phone Number: ____________________
Gender: **Male** ☐ **Female** ☐
Email Address: ____________________
Address: ____________________
Consult ☐
Emergency Contact: ____________________
Vascular Testing: ☐ **Requested Test:** ____________________
Insurance Provider: ____________________
Laterality: ____________________
Policy Number: ____________________

Referral Reason:

Reason for Referral: ____________________
Previous Imaging: ____________________

Please include:
- → **Demographics**
- → **Most Recent Office Note**
- → **Revelant Imaging results**