ADVANCED VASCULAR AND VEIN ASSOCIATES

REFERRAL FORM

REFERRAL TO: AVVA Vascular and Endovascular Surgery

PATIENT INFORMATION		
Patient's Name		
Date of Birth	**Age**	**Sex**
Patient's Phone Number	**Referral Date**	
Street Address	**City**	
State	**Zip Code**	
Primary Insurance	**Eligibility**	
Secondary Insurance	**Eligibility**	

REFERRAL INFORMATION		
Reasons for Referral (please be as detailed as possible)		
If dialysis, please circle one for dialysis days	**Dialysis Days**	
	MWF	**TTS**

REFERRING DOCTOR'S INFORMATION	
Name	**Clinic**
Phone Number	**Fax Number**

Signature

*Please fax this form and any notes, lab work, testing reports (i.e., dopplers, duplexes, echoes, CT, CTA's) to ***601-586-7071*** or email to referrals@avvams.com Please mail any imaging discs to 4436 Mangum Drive, Flowood, MS 39232

4436 Mangum Drive | Flowood, MS | 39232 | 601-586-7070 (Office) | 601-586-7071 (Fax)