



- Cardiothoracic and Vascular Surgery - JON-CECIL WALKES, M.D.
 Interventional Cardiologist - LAMIN BANGURA, M.D.
 Foot and Ankle Surgery NATHANIEL ALABI, D.P.M AKASHDEEP SINGH, D.P.M.

REFERRAL FORM

PATIENT NAME: _____ PATIENT PHONE: _____
 DATE OF BIRTH _____

Evaluate For:

- | | |
|--|--|
| <input type="checkbox"/> Peripheral Artery Disease | <input type="checkbox"/> Dialysis Access |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Non-Healing Wound |
| <input type="checkbox"/> Carotid Stenosis | <input type="checkbox"/> Leg Pain/Leg Swelling |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Aortic Aneurysm |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Sports Injury |
| <input type="checkbox"/> CABG Evaluation | <input type="checkbox"/> Bunions |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ingrown Nails |
| <input type="checkbox"/> Other: _____ | |

<p style="text-align: center;">Referring Physician:</p> <p>_____</p> <p>OFFICE PHONE: _____</p> <p>OFFICE FAX: _____</p>	<p style="text-align: center;">Insurance Information:</p> <p>HMO PPO MEDICARE MEDICAID</p> <p>Insurance Auth # for HMO Patients: _____</p> <p>Insurance Provider: _____</p> <p>Insurance Phone Number: _____</p> <p>Member ID/Policy # and Group #: _____</p>
<p>Please FAX or EMAIL the following information to our office for scheduling</p> <ul style="list-style-type: none"> -Patient Demographics -Insurance Information -MUST send recent H&P or Chart Notes -Pertinent diagnostic test results related to issue -Recent Labs <p>Kindly instruct the patient to bring the following to their appointment:</p> <ul style="list-style-type: none"> -CD or USB drive of any studies -CURRENT medication list -COPY of ID and Insurance Cards 	<p style="text-align: center;">ADDITIONAL NOTES:</p> <p>_____</p> <p>_____</p> <p>_____</p>



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