ADVANCED VASCULAR & VEIN ASSOCIATES

PATIENT REFERRAL FORM		
Patient's Name		
Date of Birth	Age	
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) Please specify if a wound is present.		
If dialysis, please circle one for dialysis days	**MWF**	**TTS**
REFERRING PROVIDER'S INFORMATION		
Name	Clinic	
Phone Number	Fax Number	

Signature

Please fax this form and any notes, lab work, testing reports (i.e., dopplers, duplexes, echos, CT, CTA's)

Flowood Location – E-mail: referrals@avvams.com Fax: 601-586-7071 Phone: 601-586-7070

4436 Mangum Drive Flowood, MS 39232

Batesville Location – E-mail: northms@avvams.com Fax: 601-952-8820 Phone: 601-586-7070

303 Medical Center Drive, Batesville, MS 38606