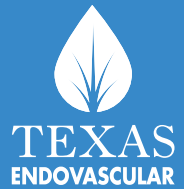




# WILLIAM C. FOX, M.D.



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Company & ID: \_\_\_\_\_

## PLEASE EVALUATE FOR FOLLOWING CONDITIONS:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Varicose Veins         | <input type="checkbox"/> Venous Ulcer         | <input type="checkbox"/> Recurrent Cellulitis     |
| <input type="checkbox"/> Swelling               | <input type="checkbox"/> Hyperpigmentation    | <input type="checkbox"/> Venous Dermatitis        |
| <input type="checkbox"/> Leg Pain               | <input type="checkbox"/> Lymphedema           | <input type="checkbox"/> Post Thrombotic Syndrome |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Spontaneous Bleeding | <input type="checkbox"/> May-Thurner Syndrome     |

Notes: \_\_\_\_\_

PLEASE EVALUATE PATIENT WITH DUPLEX VENOUS ULTRASOUND.

Referring Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

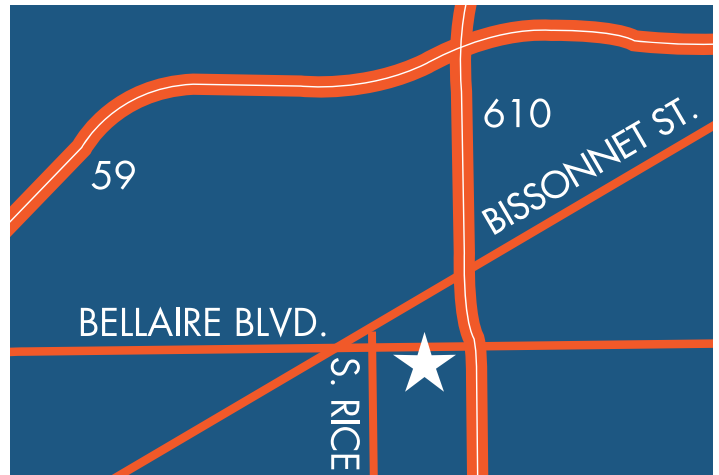
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### PLEASE FAX FORM TO: 713.575.3688

4747 Bellaire Boulevard, Suite 575 • Bellaire, TX 77401



**CALL TODAY • 713.575.3686**





# ERIC P. HARDEE, M.D.



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Company & ID: \_\_\_\_\_

## PLEASE EVALUATE FOR FOLLOWING CONDITIONS:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Varicose Veins         | <input type="checkbox"/> Venous Ulcer         | <input type="checkbox"/> Recurrent Cellulitis     |
| <input type="checkbox"/> Swelling               | <input type="checkbox"/> Hyperpigmentation    | <input type="checkbox"/> Venous Dermatitis        |
| <input type="checkbox"/> Leg Pain               | <input type="checkbox"/> Lymphedema           | <input type="checkbox"/> Post Thrombotic Syndrome |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Spontaneous Bleeding | <input type="checkbox"/> May-Thurner Syndrome     |

Notes: \_\_\_\_\_

PLEASE EVALUATE PATIENT WITH DUPLEX VENOUS ULTRASOUND.

Referring Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLEASE FAX FORM TO: 713.575.3688**

**1331 W. Grand Parkway North, Suite 210, Katy, TX 77493**



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