4747 Bellaire Blvd., Suite 575 • Bellaire, TX 77401 • Office: 713.575.3686 • Referral Fax: 713.575.3688

WILLIAM C. FOX, M.D.

TEXAS ENDOVASCULAR

Patient Name: _____ DOB: _____

Phone: _____ Cell: _____

Insurance Company & ID: _____

PLEASE EVALUATE FOR FOLLOWING CONDITIONS:

- ☐ Varicose Veins
- ☐ Swelling
- ☐ Leg Pain
- ☐ Restless Legs Syndrome
- ☐ Venous Ulcer
- ☐ Hyperpigmentation
- ☐ Lymphedema
- ☐ Spontaneous Bleeding
- ☐ Recurrent Cellulitis
- ☐ Venous Dermatitis
- ☐ Post Thrombotic Syndrome
- ☐ May-Thurner Syndrome

Notes: _____

PLEASE EVALUATE PATIENT WITH DUPLEX VENOUS ULTRASOUND.

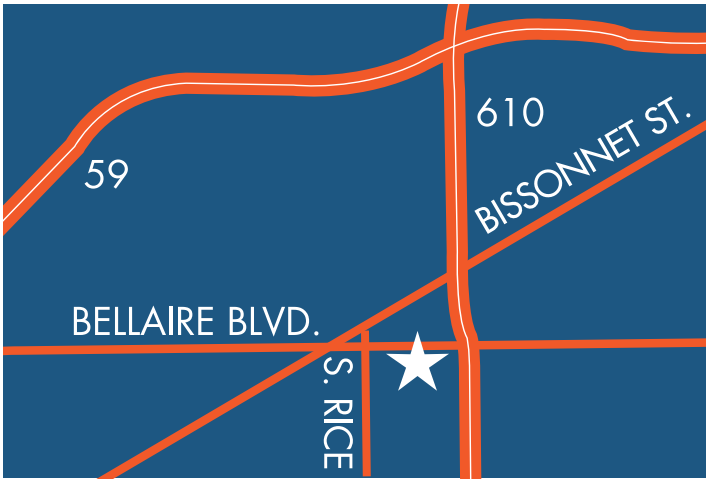
Referring Provider Name: _____ Date: _____

Phone: _____ Fax: _____

PLEASE FAX FORM TO: 713.575.3688

4747 Bellaire Boulevard, Suite 575 • Bellaire, TX 77401

CALL TODAY • 713.575.3686



1331 W. Grand Parkway N., Suite 210, Katy, TX 77493 • Office: 713.575.3686 • Referral Fax: 713.575.3688

ERIC P. HARDEE, M.D.

TEXAS ENDOVASCULAR

Patient Name: _____ DOB: _____

Phone: _____ Cell: _____

Insurance Company & ID: _____

PLEASE EVALUATE FOR FOLLOWING CONDITIONS:

☐ Varicose Veins	☐ Venous Ulcer	☐ Recurrent Cellulitis
☐ Swelling	☐ Hyperpigmentation	☐ Venous Dermatitis
☐ Leg Pain	☐ Lymphedema	☐ Post Thrombotic Syndrome
☐ Restless Legs Syndrome	☐ Spontaneous Bleeding	☐ 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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