

Office use only:

Account _____



**ADVANCED
VASCULAR THERAPY**

10000 NE Liberty Street, Suite 110, Salem, OR 97301

2480 Liberty Street NE, Ste. 110

Salem, OR 97301

503.371.1756 (P)

503.584.7971 (F)

REFERRAL TO ADVANCED VASCULAR THERAPY

DATE: _____

REFERRAL FROM: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____

DOB: _____

DX: _____

SELECT ONE ONLY – STUDY ONLY: _____ **EVALUATION AND TREATMENT:** _____

AUTH REQUESTED: YES _____ NO _____ PENDING _____

****THE FOLLOWING MUST BE INCLUDED TO PROCESS REFERRAL**:**

DEMOGRAPHICS CHART NOTES IMAGING REPORTS/LAB RESULTS

PROVIDER SIGNATURE: _____ DATE: _____

PLEASE FAX TO 503.584.7971 ATTN: REFERRALS. ONCE REVIEWED WE WILL CONTACT YOUR PATIENT.

QUESTIONS? PLEASE CALL 503.371.1759 OPTION 1

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