Office use only:

Account _____

ADVANCED
VASCULAR THERAPY

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

CREATED 1.1.2016 KG UPDATED 7.24.2020 KG