up MEDICAL

Patient Referral Form

TIN 33-0375152 NPI 1689835563

Patient is being referred for

up VASCULAR

Office Visit: ☐ New Patient ☐ Follow-up

Diagnosis: _____

Arterial: ☐ Leg Pain ☐ Claudication ☐ Ulcer / Gangrene ☐ PAD ☐ Aneurysm

Venous: ☐ Varicose Veins ☐ Edema ☐ Venous Insufficiency ☐ DVT

Carotid: ☐ Carotid Stenosis ☐ Stroke

Dialysis: ☐ Thrombosed ☐ Extreme Swelling / Pain ☐ Inadequate Access

Other: _____

Diagnostics: Vascular

Ultrasound: ☐ Right ☐ Left ☐ Bilateral

☐ Lower Extremity Arterial ☐ Upper Extremity Arterial ☐ Lower Extremity Venous

☐ Upper Extremity Venous ☐ Dialysis Access ☐ Carotid

Patient is being referred for

up FOOT & ANKLE

Office Visit: ☐ New Patient ☐ Follow-up

Diagnosis: _____

General Podiatry: ☐ Diabetic Foot Care ☐ Nail Care ☐ Pain & Swelling ☐ Ulcers

Wound Care: ☐ Dressings ☐ Debridement ☐ Skin Grafts ☐ Ultrasound

Foot / Ankle Surgery: ☐ Fracture ☐ Dislocation ☐ Revision ☐ Bunions

Other: _____

Please provide patient information on the reverse side of this form.

1.833.GET.UPMD
(1.833.438.8763)

1.833.438.8700

referrals@upmedical.com

up MEDICAL

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TIN 33-0375152 NPI 1689835563

Patient Information

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Insurance / Medical Group: _____

Referring Clinic Information

Facility / Clinic Name: _____

Referring Physician: _____

Phone Number: _____ Fax: _____

EHR Direct Address: _____

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