HEART & VASCULAR CLINICS

VEIN CLINIC OF KANSAS

PROVIDER REFERRAL FORM

Priyantha Ranaweera, MD
Ramez Smairat, MD

Hollie Hall, NP-C

Patient Information

Name: ______________________________ DOB: ______________________________

Address: ____ Phone:

Insurance Information

Carrier Name: ____

Policy ID: ______________________________ Group ID: ______________________________

Reason for Referral

- ☐ Initial Consult
- ☐ Re-Establish Care
- ☐ 24/48 hr Holter Monitor
- ☐ 30 Day Monitor
- ☐ Nuclear Treadmill
- ☐ Lexiscan
- ☐ Stress Echo
- ☐ GXT
- ☐ Tilt Table
- ☐ Echocardiogram
- ☐ Arterial Ultrasound
- ☐ Venous Insufficiency
- ☐ Venous Ultrasound
- ☐ Abdominal Aorta Ultrasound
- ☐ Carotid Ultrasound
- ☐ General Ultrasound(Kidney,Bladder,Renal, Etc)
- ☐ Echo with Bubble Study
- ☐ PFT
- ☐ Dietitian
- ☐ Wound Care

Diagnosis: ____

Notes: ____

____

Referring Provider Name: ____ Phone: ____________________

Signature: ____ Date: ____________________

Any tests ordered will need to have a prior authorization done before test will be scheduled. Please include this with the order to avoid delays in scheduling

For Cardiology consults, please send ALL CARDIAC RELATED RECORDS, recent progress notes with complete medication list, and any tests the patient has done such as: Echo, EKG, Stress Test.