



FAX: (480) 616-0603

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Phoenix AZ 85015

NPI #: 1508364860

PLEASE INCLUDE: Face sheet, insurance cards, H&P, medication list, & any results of diagnostic screenings performed

Today's Date: _____ Status: HIGH PRIORITY STANDARD

Patient's Name: _____ DOB: _____

Phone #: _____ Primary Insurance: _____

Referring Physician: _____

Office Phone: _____ Office Fax: _____

Treatment: Vascular Consult: Evaluate & Treat
 Other: _____

Indications: Pain Ulceration Open Sore Discoloration
 Swelling Gangrene Drainage Other: _____

ALLERGIES (including contrast allergies):

Blood Thinners: Coumadin Aspirin Plavix Eliquis

Diabetic? NO YES - Insulin Type: _____

Emergency Contact: _____ Phone #: _____

Need Transportation? YES NO

****If patient comes in with undressed or weeping wound, is it okay for us to compress and/or dress during consult if it's an urgent need? YES NO**

Referring MD/DPM Signature

Date