



REFERRAL FORM

To schedule a consultation or procedure, FAX this form to: (828) 277.0082

Patient Name: _____ DOB: _____

Phone Number: _____ SSN: _____

Patient Address: _____

Diagnosis: _____

Referring Provider: _____ Return Fax: _____

Insurance Carrier: _____ Insurance ID #: _____

Uninsured

Reason For Vascular Surgery Referral/Diagnosis:

Dialysis? _____ M, W, F _____ T, Th

Creatinine Level: _____

Allergies: _____

Referring Provider:

Referring Fax:

Primary Care Physician:

Physician Preference:

First Available

John Henretta, MD

Lemuel Kirby, MD

Douglas MacMillan, MD

Emma Rooney, MD

Weldon Williamson, MD

All Vascular Surgery Referrals Must Include the Following:

- Medical history/office notes
- All imaging associated with the referral
- Labs (including A1C, Renal, INR, CBC, platelet count)
- Current medication list
- Copy of insurance card(s)

Andy Brown, MD Daniel Brown, MD Toby Cole, MD Robert Conklin, MD

Trevor Downing, MD James R. Field, MD Joshua Hubbard, MD Kristy Rutan, MMS, PA-C

Please fax completed form, pertinent medical records,
demographic information, and recent diagnosis studies to (828) 213.9091