Vascular Institute of Kentucky

Alexander Hou, MD
617 – 23rd Street, Suite 445
Ashland, KY 41101
Off: (606) 327-5628 Fax: (606) 327-5649

PATIENT REFERRAL FORM

Please complete the following information for patient referral. Please note that we do not accept ***Minors and Workers Compensation***:

Please fax a copy of insurance card, recent labs, radiographic results, office notes, medication list and reason for referral with this form.

Referring Physician

Date _____

Referring Physician _____

Phone # _____ Fax # _____

Contact Person _____

Patient Information

Patient Name _____

Address _____

_____

Home Phone _____ SS # _____

Insurance _____

Date of Birth _____

Reason for Referral _____

Studies Requested

No Pre-Appointment Testing is required. Please fax all relevant office documents and test results already performed along with this form. Thank You.

APPOINTMENT DATE & TIME: _____

Please Notify Your Patient of Appointment

THANK YOU FOR YOUR REFERRAL
PLEASE CALL OUR OFFICE AFTER FAXING TO COMFIRM APPOINTMENT*