



**Florida
Surgical
Clinic**

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Patient Referral Form

Patient's name: _____

Primary Insurance: _____

Date of Birth: _____

Secondary Insurance: _____

Last four SSN: _____

Ins. Authorization Number: _____

Patient's phone number: _____

Patient's phone number: _____

When does the patient need to be seen?

Referring provider: _____

- ASAP
- 1-2 weeks
- Next available

Referring provider phone number: _____

Referring provider fax number: _____

Reason for Referral

- | | |
|--|---|
| <input type="checkbox"/> Abdominal aortic aneurysm | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Arterial disease of the arm | <input type="checkbox"/> Amputation site evaluation |
| <input type="checkbox"/> Arteritis | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Claudication | <input type="checkbox"/> Breast mass |
| <input type="checkbox"/> DVT (Deep Vein Thrombosis) | <input type="checkbox"/> Cholecystitis |
| <input type="checkbox"/> Diabetic foot wound | <input type="checkbox"/> Cholelithiasis |
| <input type="checkbox"/> Dialysis access | <input type="checkbox"/> Colon cancer |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Colon polyps |
| <input type="checkbox"/> Mesenteric ischemia | <input type="checkbox"/> Cancer/tumor needing coiling |
| <input type="checkbox"/> Pelvic congestion syndrome | <input type="checkbox"/> Diverticular disease |
| <input type="checkbox"/> Peripheral aneurysm | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> PAD (Peripheral Arterial Disease) | <input type="checkbox"/> Inguinal hernia |
| <input type="checkbox"/> PE (Pulmonary Embolism) | <input type="checkbox"/> Lipoma/skin mass |
| <input type="checkbox"/> Renovascular disease | <input type="checkbox"/> Port placement |
| <input type="checkbox"/> Thoracic aortic aneurysm | <input type="checkbox"/> Port removal |
| <input type="checkbox"/> Thoracic aortic disease | <input type="checkbox"/> Splenic mass/splenomegaly |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Vascular Ultrasound |
| <input type="checkbox"/> Venous insufficiency | <input type="checkbox"/> Ventral/umbilical hernia |
| <input type="checkbox"/> TIA/Stroke | <input type="checkbox"/> Wounds |
| <input type="checkbox"/> Wounds | <input type="checkbox"/> Other: _____ |

Please send or attach most recent history & physical, progress notes, insurance information, medication list, and recent tests/lab work for faster processing.

Additional Notes: _____