



PATIENT REFERRAL

Please FAX completed form to (248)
855-5455 **Physician Liaison: Diana Wilsher**

Patient Information

Name: _____

D.O.B: _____

Phone #: _____

Insurance: _____

Insurance ID #: _____

Referring Doctor Information

Name: _____

Name of Practice: _____

Specialty: _____

Office Address: _____

Address Continued: _____

Phone #: _____ Fax #: _____

Primary Diagnosis: Varicose veins with other complications -

The above patient needs treatment by a specialist for signs and symptoms of venous insufficiency.

Confidentiality Notice: Confidential Health Information Enclosed

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7125 Orchard Lake Road, Suite 120, West Bloomfield, MI, 48322

Dr. Diana Wilsher - Vascular Surgeon

Phone: 248.855.5355

MetroVeinCenters.com

Fax: 248-855-5455

