Date: [Date]

To: [Consultant Name/Vascular Specialist]
Facility: [Clinic/Hospital Name]
Address: [Clinic Address]

RE: Patient Consultation and Vein Mapping
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance: [Insurance Provider & ID Number]

Dear Dr. [Consultant Last Name],

I am referring this patient to your clinic for a formal vascular consultation and bilateral/unilateral lower extremity vein mapping.

Clinical Indications:

- [e.g., Chronic Venous Insufficiency]
- [e.g., Symptomatic Varicose Veins]
- [e.g., Pre-operative mapping for CABG or dialysis access]
- [e.g., History of DVT or Phlebitis]

Patient Symptoms:

[Describe symptoms such as edema, pain, heaviness, or skin changes].

Requested Services:

- Physical Examination and Consultation
- Duplex Ultrasound Vein Mapping
- Treatment recommendations as indicated

Please find the patient's recent medical records and medication list attached. Thank you for your expertise in the evaluation of this patient. Please forward your consultation report and ultrasound findings to my office via fax at [Fax Number].

Sincerely,

[Doctor Signature]
Physician Name: [PCP Name]
NPI Number: [NPI Number]
Office Contact: [Phone Number]