Date: [Insert Date]

To: [Referring Physician Name]
Fax/Address: [Recipient Address/Fax]

RE: Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Examination Date: [Date of Consult]

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] for a venous insufficiency evaluation and vein mapping. The patient presents with symptoms of [List Symptoms, e.g., leg pain, swelling, heaviness, or varicose veins].

Clinical Findings:
Physical examination of the lower extremities reveals [Describe findings, e.g., CEAP Classification, edema, skin changes].

Duplex Ultrasound / Vein Mapping Results:

- **Right Lower Extremity:** [Describe reflux in Great Saphenous Vein, Small Saphenous Vein, or Deep System. Note vein diameters.]
- **Left Lower Extremity:** [Describe reflux in Great Saphenous Vein, Small Saphenous Vein, or Deep System. Note vein diameters.]
- **Perforators:** [Note any incompetent perforating veins]
- **Deep Venous System:** [Rule out DVT or chronic occlusion]

Impression:
[Insert Diagnosis, e.g., Symptomatic Chronic Venous Insufficiency]

Plan of Care:
Based on the mapping results, the following treatment plan is recommended:
[ ] Conservative management (Compression therapy for [X] months, elevation, exercise)
[ ] Endovenous Laser/Radiofrequency Ablation of [Vein Name]
[ ] Ultrasound-Guided Foam Sclerotherapy
[ ] Ambulatory Phlebectomy

We will proceed with [Proposed Procedure] pending insurance authorization. A follow-up report will be sent upon completion of the procedure.

Sincerely,

[Doctor Signature]
[Doctor Name, Title]
[Practice Name]