REGION VEIN
EXCEPTIONAL VEIN CARE

Demetrios J. Karamichos, MD
RPVI, RVT, DABVLM, FAAFP

PROVIDER REFERRAL REQUEST FORM

Please complete the following information and fax to our office at 219.881.8776
Our staff will contact your patient to schedule them.

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____

Reason for referral: (please check all that apply)

- ☐ Varicose veins/chronic venous insufficiency
- ☐ Chronic recurrent lower extremity edema
- ☐ Superficial phlebitis
- ☐ Bleeding from a vein (phleborrhagia)
- ☐ Venous ulceration
- ☐ Spider Veins/Reticular Veins
- ☐ Dermatitis/lipodermatosclerosis
- ☐ Lymphedema
- ☐ Restless leg syndrome
- ☐ Hand sclerotherapy
- ☐ Facial sclerotherapy

Have prescription strength (>20 mmHg) graduated compression stockings been prescribed? ____

Additional History (labs/ultrasound/imaging): _____

_____

_____

Referring Provider Information:

Provider Name: _____ Phone: _____

Address: _____ Fax: _____

Email: _____ NPI: _____

For **EPIC** Patient Referrals to Dr. Karamichos:

- In patient's profile GENERAL tab, "CLASS" field-click "OUTGOING"
- In the REFERRED TO section, "PROVIDER" field, type in "KARAMICHOS" and Dr. Karamichos/RegionVein will pop up, select this
- Click ACCEPT at the bottom of the page
- Print Patient Referral Page
- Fax Patient Referral Page to Region Vein at **219.881.8776**

Thank you for your patient referrals to Region Vein.

Please call us at 219.595.3095 with any questions.