



**Mark McQuaid, DABVLM, FACS**

**REQUEST FOR CONSULTATION / REFERRAL**

Date:	Referring Provider:
Patient Name:	DOB:
Patient Phone:	Insurance:

**REASON FOR REFERRAL — PLEASE EVALUATE AND TREAT FOR**

- |  |   |
|--|---|
| <input type="checkbox"/> Spider/Varicose Veins         | <input type="checkbox"/> Skin Changes (Hyperpigmentation, Dermatitis) |
| <input type="checkbox"/> Leg Swelling / Edema          | <input type="checkbox"/> Venous Ulcers / Non-healing wounds           |
| <input type="checkbox"/> Leg Pain / Aching / Heaviness | <input type="checkbox"/> Recurrent Cellulitis                         |
| <input type="checkbox"/> Restless Legs / Cramping      | <input type="checkbox"/> Bleeding Varicosities                        |
| <input type="checkbox"/> Fatigue / Tired Legs          | <input type="checkbox"/> Other: _____                                 |

If clinical suspicion for chronic venous insufficiency exists and no contraindications are present, graduated compression stockings (20–30 mmHg or higher) may be recommended until definitive evaluation and treatment.

**WHAT YOUR OFFICE CAN EXPECT**

- |  |  |
|--|--|
| • Patient contacted within 1–2 business days | • Communication sent to referring provider |
| • Insurance verification prior to visit      | • Patient education and care coordination  |
| • Consultation + ultrasound often same visit |  |

**NETWORK PARTICIPATION**

**Texas Health Physicians Group (THPG)** Specialist Referral Network  
**Southwestern Health Resources Physician Network (SWHR)** — Preferred Specialist  
**Baylor Scott & White Quality Alliance (BSWQA)** — Participating Provider

**CONTACT INFORMATION**

McQuaid Vein Care — 777 Main Street, Suite 100, Frisco, TX 75036  
**Appointments:** 972-378-5347 | **Fax:** 972-378-0916 | [McQuaidVein.com](http://McQuaidVein.com)

Provider Signature: \_\_\_\_\_