

**Referral Form for VITA and Vita Veins**  
Vascular Interventional of Thomasville, Associates  
**Dr. Timothy Daniel and Dr. Craig Yokley**

**Date of Referral:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Patient Phone Number:** \_\_\_\_\_

**Reason for Referral: (Circle one)**

**Arterial Disease**

**Venous Disease**

**Fibroid Disease**

**Other:** \_\_\_\_\_

**Referring Doctor's Name:** \_\_\_\_\_

**Referring Doctor's Office Number:** \_\_\_\_\_

**Referring Doctor's Fax Number:** \_\_\_\_\_

PLEASE SEND MOST RECENT CHART NOTE; MEDICATION LIST & RADIOLOGY REPORT

**FAX TO: 229-226-0195**