



*Connecticut  
Vein Care*

**CONSULT REQUEST**

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

INSURANCE: \_\_\_\_\_

SCHEDULE APPOINTMENT FOR DR. SULLIVAN \_\_\_\_\_

DR. RUBY \_\_\_\_\_

DR. FECTEAU \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

CONSULTATION \_\_\_\_\_

TREATMENT AND/OR MANAGEMENT \_\_\_\_\_

DATE OF APPOINTMENT: \_\_\_\_\_

MADE BY: \_\_\_\_\_