BARRIE VEIN CLINIC

REFERRAL FORM FOR CLINICAL CONSULTATION

PATIENT'S NAME _____ D. O. B. _____

OHIP #_____ TEL#_____

CLINICAL INFORMATION

❒ LEG PAIN / SWELLING / DISCOLORATION

❒ VARICOSE / SPIDER VEINS

❒ LEG ULCER

❒ PVD

❒ OTHER _____

_____

SIGNIFICANT HEALTH ISSUES _____

_____

REFERRING DOCTOR_____

BILLING #_____ TEL. #_____

ADDRESS:_____ FAX# _____

Bring loose fitting shorts to be examined in

60 Bell Farm Rd. Unit #1 Barrie, ON L4M 5K5 - 705-915-1199