Barrie Vein Clinic

www.barrieveinclinic.ca

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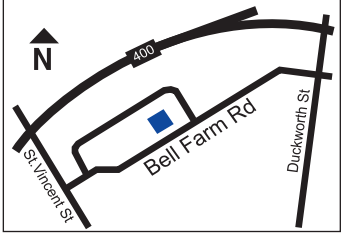

REFERRAL FORM FOR CLINICAL CONSULTATION

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