ONTARIO VEIN CLINICS

MEDICAL REFERRAL FORM | VEIN CONSULTATION

PATIENT INFORMATION

Full name: _____

Date of birth: _____

Telephone: _____

OHIP number: _____

REASON FOR CONSULTATION | CHECK ALL THAT APPLY

- ☐ Varicose veins
- ☐ Spider veins
- ☐ Leg pain, heaviness or swelling
- ☐ Skin changes / discoloration
- ☐ Chronic venous insufficiency
- ☐ Venous ulcer / poor healing
- ☐ Recurrent varicose veins
- ☐ History of DVT / phlebitis
- ☐ Other: _____

Relevant clinical history / specific concern:

_____

_____

_____

REFERRING PHYSICIAN INFORMATION

Referring physician: _____

Billing number: _____

Clinic / organization: _____

Telephone / fax: _____

OFFICE USE ONLY

Appointment date / time: _____

2525 Old Bronte Road, Suite 310, Oakville, ON L6M 4J2
Phone: 905-849-1835 | Fax: 905-849-3712
www.ontarioveinclinics.com