



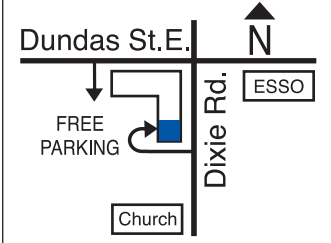
Canadian Vein Institute

www.canadianveininstitute.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