Windsor Vein Centre

Physician Referral Form

Tel: (519) 250-4284
Fax: (519) 256-7905
880 N Service Rd, Windsor ON N8X 3J5
windsorveincentre.org

URGENCY: ☐ Routine (4–6 weeks) ☐ Soon (1–2 weeks) ☐ Urgent (within 48 hrs)

1. PATIENT INFORMATION

Last Name | First Name

Date of Birth (DD/MM/YYYY) | Health Card Number | Version Code

Address | City | Postal Code

Phone (Home) | Phone (Cell) | Email (optional)

Sex: ☐ Male ☐ Female ☐ Other Preferred Contact: ☐ Phone ☐ Cell ☐ Email

Interpreter required? ☐ No ☐ Yes — Language:

2. REFERRING PHYSICIAN

Physician Name | CPSO / License #

Clinic / Practice Name

Address | City | Postal Code

Phone | Fax | Date of Referral

3. REASON FOR REFERRAL (CHECK ALL THAT APPLY)

Venous Conditions:

☐ Large Varicose Veins — EVLT / surgical Rx ☐ Venous Leg Ulcer

☐ Spider Veins / Telangiectasias ☐ Chronic Venous Insufficiency (CVI) ☐ Post-thrombotic Syndrome

Requested Procedure / Consultation:

☐ Venous Duplex Ultrasound ☐ Endovenous Laser Treatment (EVLT) ☐ Sclerotherapy

☐ Ultrasound-Guided Sclerotherapy (UGS) ☐ Consultation Only ☐ Other (see notes)

DVT / Thrombosis:

☐ Suspected DVT ☐ Confirmed DVT — surveillance ☐ Superficial Thrombophlebitis

4. CLINICAL INFORMATION

Relevant History / Symptoms:

Symptoms:

☐ Leg pain / aching ☐ Swelling / oedema ☐ Heaviness ☐ Itching / burning ☐ Skin changes

☐ Night cramps ☐ Restless legs ☐ Bleeding ☐ Ulceration

CEAP Classification (if known) | Duration of Symptoms

Previous Vein Treatment?

☐ None ☐ Sclerotherapy ☐ Surgery ☐ Laser ☐ Other:

Current Medications (especially anticoagulants, NSAIDs):