VASCULAR SURGERY REFERRAL FORM

Dr. Cooper & Dr. Ducas
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Barrie, ON L4M 7G1
Phone: 705-881-1010
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Place patient addressograph here

Patient name:
Date of Birth (YYYY-MM-DD):
Address:
Phone Number:
Health Card Number:

REASON FOR REFERRAL:
(*Circle all that apply)*

Peripheral Vascular Disease
- Critical Limb Ischemia (rest pain, gangrene, tissue loss)
- Claudication

Aortic Aneurysm

Varicose Veins

Other *(please describe)***:**

Carotid Disease
- Symptomatic (TIA or stoke within 120 days)
- Asymptomatic

Dialysis Access
- New Fistula creation
- Current fistula with concerns

CLINICAL HISTORY

INVESTIGATIONS
(Circle all that apply)

CT Scan
Ultrasound
MRI
Other

** Please attach all relevant imaging reports **

MEDICATIONS
(please list all medications or attach list)

REFERRING PHYSICIAN INFORMATION

Name:
Date of Referral:
Phone Number: 705-728-9802 RVH ER
Billing Number: