Stratford Vein Clinic

471 Hibernia Street Stratford
ON N5A 5W2
email: info@stratfordveinclinic.com
Tel: 226 786 4515
Fax: 226 779 4227

Referral Form

PATIENT INFORMATION

Name

Phone number

Health card apply label here

Date of Birth

Address

Email address

REFERRING PROFESSIONAL

Name

Phone number

Fax number

Email address

Billing number

Office address

Reason for referral (check all that apply)

- ☐ Visible Varicose Veins
- ☐ Skin discoloration
- ☐ Ankle edema
- ☐ Leg pain/discomfort
- ☐ Skin ulcer ☐ Active ☐ Healed
- ☐ Left leg
- ☐ Right leg
- ☐ Both legs
- ☐ Other reason (please explain)

Relevant past medical history (check all that apply)

☐ DVT ☐ Never ☐ Yes **R** leg ☐ Yes **L** leg When?

☐ Previous vein intervention - if yes, specify

Additional comments

PLEASE INCLUDE AN UPTODATE PAST MEDICAL AND SURGICAL HISTORY AND CURRENT LIST OF MEDICATION. IF AVAILABLE PLEASE SEND VEIN DOPPLER ULTRASOUND RESULTS

Signature _____ Date_____