

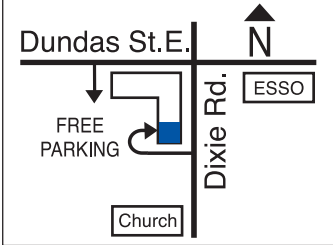


Canadian Vein Institute

www.canadianveininstitute.ca

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REFERRAL FORM

PATIENT'S NAME _____ D. O. B. _____

TEL# _____ DATE _____

CLINICAL INFORMATION

- LEG PAIN / SWELLING / DISCOLORATION
- VARICOSE / SPIDER VEINS
- LEG ULCER
- PVD
- OTHER _____

SIGNIFICANT HEALTH ISSUES _____

REFERRING DOCTOR _____

BILLING # _____ TEL. # _____

Bring loose fitting shorts to be examined in