**Referral Form for Patients with Varicose Veins**

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  |  |  | | |
| Address  Post Code |  | Home tel. no. |  | | |
| Work tel. no. |  | | |
| Mobile no. |  | | |

**Referral Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Referring clinician |  | Preferred clinician  (if applicable) |  | | |
| GP Practice/ Department |  | New referral? |  | Re-referral? |  |
| Date of referral |  | Date last seen |  | | |
| Date of consultation |  | Dates not available |  | | |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required?: | Yes |  | No |  |  | Wheelchair access required? | Yes |  | No |  |
| Language: |  | | | | |  |  | | | |
| Communication & Accessibility Needs: | Hearing: | | | | | Learning Disability: |  | | | |
| Vision: | | | | | Other Disability: |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

|  |  |  |
| --- | --- | --- |
| **Symptoms in relation to varicose veins: - please follow guidelines on Microguide.** | **Right** | **Left** |
| Bleeding in the past? |  |  |
| Ulcer present? |  |  |
| Past ulcer? |  |  |
| Lipodermatosclerosis or venous eczema? |  |  |
| Recurrent thrombophlebitis? |  |  |
| Pain/aching - fully relieved by a class II stocking? |  |  |

|  |  |  |
| --- | --- | --- |
| **Other Medical History:** | **Right** | **Left** |
| Fracture of femur? |  |  |
| Previous DVT? |  |  |
| Previous vein surgery? |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Medication:** |

**Please make appointments via e-RS. For advice, you can contact the Vascular Nurse Co-ordinator in Salisbury during office hours on: 01722 336262 x 4937 or bleep 1112.**

**For Office use only:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date referral received |  | Investigations required |  |
| Date of outpatient appointment |  | Time of appointment |  |