OSLER VASCULAR & VEIN
COMPREHENSIVE VASCULAR CARE

Osler Vascular & Vein West
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Vascular Medicine Clinic Referral Form

NB: *In light of the current COVID-19 pandemic, both virtual and in-person assessments are being provided.*

Patient Demographics

Name: _____ Gender: _____
DOB: _____ HCN: _____
Home Phone #: _____ Cell Phone #: _____
Address: _____ Email: _____

Arterial Disease

☐ Vascular Risk Reduction (primary prevention in at-risk patient)

☐ Secondary Prevention (patient with known arterial disease such as PAD, carotid stenosis, AAA etc)

Venous Disease

☐ Leg Swelling NYD

☐ Medical management of chronic venous insufficiency

☐ Work-up and management of VTE

Alternate Reason for Referral

*** Please attach a list of up-to-date medications and relevant investigations**

Urgency: ☐ Routine (2-4 weeks) ☐ Urgent (<2 weeks) ☐ Emergent (please call)

Referred by: _____ _____ _____ _____
(Printed Name) (Signature and Designation) (Billing Number) (Date)

Please provide your patient with the handout attached and inform them of the referral.

Our clinical secretary will contact your patient to arrange an appropriate time for virtual or in-person assessment.