**Referral Form for Patients with Intermittent Claudication**

**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: |  | | | | Learning Disability: |  | | | |
| Hearing: |  | | | | Other disability needing consideration: |  | | | |
| Vision: |  | | | |

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

**Symptoms in relation to PVD**

|  |  |  |
| --- | --- | --- |
|  | **Right Leg** | **Left Leg** |
| Intermittent claudication? |  |  |
| Rest pain? |  |  |
| Please refer to leg ulcer nurse specialist if ulcer present | | |

**Other Medical History:**

|  |  |
| --- | --- |
| **If appropriate your patient will undergo a treadmill test. Please complete the following to ensure your patient is fit to undergo this test. A “yes” response will automatically exclude your patient from a treadmill test.** | |
| Recent MI (last 3m) | Yes  No |
| Aortic Stenosis | Yes  No |
| Arrhythmia | Yes  No |
| Awaiting angina Ix | Yes  No |
| Fit for treadmill test | Yes  No |

**Risk Factors:**

|  |  |
| --- | --- |
| Smoking | Yes  No |
| Hypertension | Yes  No |
| Diabetes | Yes  No |

**A recent ABPI will help prioritise your request. Result: Right: Left:**

|  |
| --- |
| **Medication:**  **Signed:** |
| **Please make appointments via ESR.**  **In case of critical Ischaemia please use the Dorset and Wiltshire Vascular Network Emergency Pathways.**  **For advice during office hours you can contact the SFT vascular nurse co-ordinator on telephone 01722 336262 x 4937 or bleep 1112** |

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| --- |
| Additional instructions/comments: |