**Referral Form for Patients with Varicose Veins**

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  |  |  |
| AddressPost 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? | **[ ]**  | **[ ]**  |
|  |  |  |
|  |  |  |
|  |  |  |

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| --- |
| **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 |  |