East Toronto Vascular Clinic

VASCULAR SURGERY REFERRAL FORM

1805 Queen Street East tel: 416 691.2030 fax 416 259.7975
info@etvc.ca www.etvc.ca

Patient Information

Name: ☐ Male ☐ Female

DOB:

Address:

Patient Phone Number:

Patient Email:

Referring MD:

Health Card #: Family MD:

** At this time we cannot accommodate patients on stretchers, oversized wheelchairs or those that cannot transfer independently

** ETVC will arrange relevant non-invasive testing

VASCULAR SURGEON:

☐ DR. A. DUECK

☐ DR. A. KAYSSI

☐ FIRST AVAILABLE APPOINTMENT

VASCULAR SURGERY CONSULT:

Reason for referral:

ARTERIAL

☐ Aneurysm

☐ Peripheral Arterial Disease

- ☐ Claudication
- ☐ Rest/Night Pain
- ☐ Ulcer/Tissue loss

☐ Carotid Stenosis

☐ OTHER:

VENOUS

☐ Varicose Veins

☐ DVT/CVI

☐ Venous Ulcer

☐ Edema