Referral Form – Vascular

PLEASE COMPLETE THIS FORM IN **BLOCK CAPITALS IN BLACK INK**

Cambridge HEART CLINIC

Patient Number (For Clinic use only):		
1 REFERRAL DETAILS		
Date of request:	Date required:	Patient Type:
Time required:	AM ☐ PM ☐	Self Pay ☐ Insured ☐
2 PATIENT DETAILS		
Title:	First Names:	Surname:
Age:	DOB:	Sex:
Address:		
Postcode:	Email Address:	
Home Tel:	Work Tel:	Mobile Tel:
3 REFERRING DOCTORS DETAILS		
GP Name:	GP Tel:	
GP Address:		
	GP Postcode:	
GP Fax:	GP Email:	

4 TYPE OF REFERRAL			
New Vascular Consultation ☐	**Specific Tests Required** ☐		
Follow-up Vascular Consultation ☐	Aorta ☐	Carotid ☐	
	Venous Left Leg ☐	Venous Right Leg ☐	
	Arterial Left Leg ☐	Arterial Right Leg ☐	
	Arterial Bilateral ☐	Venous Bilateral ☐	

5 REASON FOR TEST AND RELEVANT CLINICAL DETAILS

6 DRUG HISTORY	**7 ALLERGIES**

8 REFERRING DOCTORS SIGNATURE

REFERRAL FAX HOTLINE: 01223 349348