REFERRAL

Vein Health
MEDICAL CLINIC

PATIENT DETAILS

First Name: _____

Last Name: _____

Date of Birth:_____ Phone: _____

Email: _____

Referral for consult and management of patient for
Duplex Ultrasound Scan for assessment and treatment of:

- ☐ Varicose Veins
- ☐ Spider veins
- ☐ Pelvic Veins Congestion
- ☐ Venous Malformations
- ☐ DVT/Swollen Leg
- ☐ Other

CLINICAL NOTES

_____

_____

_____

_____

REFERRING DOCTOR

Full name: _____

Address: _____

Phone: _____ Provider #:_____

Email/fax: _____

Practice: _____

Signature: Date:

ROOMS

10/45 Collins St, Melbourne
103/135 Macquarie St, Sydney
Ph: (03) 9662 1863
Em: info@veinhealth.com.au

DOCTOR

Dr Peter Paraskevas
Phlebologist, MBBS FACP
FRACGP C.Vasc.Ult.

Paras Clinic

THE AUSTRALASIAN
COLLEGE OF
PHLEBOLOGY