Own Health Referral Form

TEL: (289) 275 - 8826 | FAX: (289) 812-3778

PATIENT INFORMATION

Full Name: _____ DOB (DD/MM/YYY): _____

OHIP #: _____ Tel #: _____

Address: _____

REASON FOR REFERRAL

☐ Urgent

Wound / Ulcer ☐ Lower extremity wound ☐ Diabetic foot ulcer / wound ☐ Venous ulcer *If available, provide wound imagery.*	Vascular Assessment ☐ Carotid and lower extremity assessment ☐ Aneurysmal disease ☐ Vasculitis ☐ Foot care education / assessment *Imaging report is required.*
Peripheral Venous Disease ☐ Varicose veins ☐ Lower extremity edema ☐ DVT / SVT *Picture(s) of varicose veins is required.*	Peripheral Arterial Disease ☐ Peripheral arterial assessment ☐ Claudication ☐ Lower extremity pain *Arterial ultrasound report is required.*

Clinical History:

Past Medical History:

REFERRING PROVIDER INFORMATION

Referring Physician: _____

Billing #: _____ Tel #: _____ Fax #: _____