SI Vascular Care
Specialist Integrated Vascular Care

SPECIALIST CONSULTATION REFERRAL FORM

Assessment & management of arterial, venous & complex wound conditions

For appointment – email: referrals@sivascular.com.au I HealthLink: sivacare I Phone: 02 7245 4746 I Fax: 02 7245 4742

Patient Details

Name:	**DOB:**
Address:	
Phone:	**E mail:**
Medicare:	**Health Fund:**

Clinical Information / Reason for Referral

Referral Reason

- ☐ **Peripheral arterial disease / claudication**
- ☐ **Peripheral artery disease – CLTI (Chronic Limb Threatening Limb Ischaemia)**
- ☐ **Carotid artery disease**
- ☐ **Aneurysm**
- ☐ **Varicose veins / venous disease**
- ☐ **Non-healing wound / ulcer**
- ☐ **Diabetic foot / limb threat**
- ☐ **Dialysis access**
- ☐ **Thoracic outlet syndrome**
- ☐ **Other vascular concern**

Referring Clinician Details

Referring Clinician:	**Provider Number:**
Practice Details:	
Phone:	**Fax:**
Signature:	**Date:**