AlfredHealth

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REFERRAL FOR VASCULAR INVESTIGATIONS

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Last name*	Detient deteile									*			
Date of birth* Sex at birth: Female Male Another term	Patient details					1				^ma	anda	atory fields	
Gender identity	Last name*					First	name	e/s*					
Address Medicare No Ref No Ref No Ref No Stapiry Medicare No Bulk Bill Private TAC WorkCover DVA Pensioner Other Aboriginal status Not Aboriginal or Torres Strait Islander Prefer not to answer Not specified Interpreter Yes No Language Cultural considerations / support needs Contact Person Name Relationship Telephone Investigations required Region Vessels Indication Side Neck Duplex Ultrasound Privombosis (central) Prombosis Left Duplex Ultrasound Arteries Native vessels Left Bypas grafts (specify) Right Right Duplex Ultrasound Lower limb Duplex Ultrasound Propagation Right R	Date of birth*	Sex at birth: ☐ Female ☐ Male ☐ Another term											
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Bulk Bill Private TAC WorkCover DVA Pensioner Other	Address	Telephone											
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Clinical question/s													
Referrer details	Referrer detail	S											
Referrer's Name Provider Number	Referrer's Name				Provide	er Num	nber						
Address Date of referral	Address				-				Date	of referra	al		
Telephone Fax Email	Telephone				Fax				Emai	I			
Copies to	Copies to												

Return referral to: E <u>vascularlab@alfred.org.au</u> or F 03 9076 3484 Enquiries: T 03 9076 2444 Ian Ferguson Vascular Laboratory, Ground Floor, **The Alfred Centre**, 99 Commercial Road, MELBOURNE, 3004