Send to:
Dr. A. Matz MD, FRCS, FACS
Phone: 1-888-876-8346
Fax: 1-705-880-1211
Email: office@canadaveinclinics.ca
www.canadaveinclinics.ca

REFERRAL REQUEST

Referring Physician/Practitioner:

Name: ______________________________________

Address: ____

____

Phone: _________________________

Fax: ___________________________

Kindly see the following patient:

Name: _______________________________________

Address: ____

____

Phone: ______________________________

DOB: _______________________________

Health Card: _________________________

Reason for referral: Varicose veins

- ○ **Right Leg**
- ○ **Left Leg**
- ○ **Both**

Additional Comments:

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___________________________ ______________________________

Signature Date