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OHC Vascular

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PATIENT INFORMATION

Last Name:
First Name:
DOB: Gender:
Tel: Mobile:
Healthcard #:
Address:

BOOKING TRIAGE REQUEST

- Requested date/interval:
- First available
- Urgent - *please send referral and call to speak with triage officer for urgent/STAT requests*

ARTERIAL

- Lower Extremity (Legs)** - *includes abdominal aorta/iliacs*
 - Diagnosis of PAD/claudication
 - Rest pain/wound
 - Post surgical bypass/angioplasty
 - EVAR/AAA/surgical graft surveillance
 - Pseudoaneurysm
 - Other - please specify below
- Carotid Artery**
 - Bruit evaluation
 - Vertigo/dizziness/syncope
 - TIA/stroke
 - Other - please specify below
- Upper Extremity (Arms)**
 - Diagnosis of PAD
 - Post surgical/angioplasty
 - Aneurysm/pseudoaneurysm
 - Other - please specify below
- Abdominal (limited)**
 - Mesenteric ischemia
 - Other - please specify below
- AV Access/Fistula surveillance**

VENOUS

- Lower Extremity (Legs)** - *includes IVC/iliacs*
- Upper Extremity (Arms)**
- Rule out DVT/SVT
- Venous valvular incompetence/varicose veins
- Pre-op vein mapping
- Other - please specify below

VASCULAR SURGERY CONSULTATION

- First available
 - Urgent (<1 week)
 - Consult if abnormal diagnostic test
- All interpreting/consulting physicians are active clinical staff at Trillium Health Partners*

Additional clinical information relevant to the request:

Referred by: Billing #:
Telephone: Fax: Date: Signature: