**VARICOSE VEINS REFERRAL FORM**

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| **\*To:** | **Referral Date:** **<Today's date>** |
| **\*Specialty:** | **\*Subspecialty** (*if appropriate)*: |
| **\*Provider Booking Department** (*Insert provider organisation*): | |

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| **Patient Details** | | **GP Details** | |
| **Forename:** | <Patient Name> | **Referring GP:** | <GP Name> |
| **Surname:** | <Patient Name> | **Registered GP:** | <GP Name> |
| **Date of Birth:** | <Date of birth> | **Practice:** | <Organisation Details>  <Organisation Address> |
| **NHS No:** | <NHS number> |
| **Gender:** | <Gender> |
| **Ethnicity:** | <Ethnicity> |
| **Hosp No** (if known)**:** |  |
| **Address:** | <Patient Address> |
| **Telephone:** | <Organisation Details> |
| **Fax:** | <Organisation Details> |
| **Practice code:** | <Organisation Details> |
| **Home Tel No:** <Patient Contact Details>  **Work Tel No:** <Patient Contact Details>  **Mobile Tel No:** <Patient Contact Details> | | | |

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| **CLINICAL THRESHOLD - VARICOSE VEINS** |
| Instructions for use:  Please refer to policy for full details.  Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.  Treatment of varicose veins in secondary care is considered a low priority treatment and will only be funded by the CCG if the criteria below have been met. Treatment will NOT be funded for cosmetic reasons or in pregnancy.   |  |  | | --- | --- | | Patients can be considered for surgery if they meet the following criteria | Tick as appropriate | | Patient’s BMI is 30 or less\* **AND**  (Completion of Get Fit First 6 month health improvement does not negate this criteria due to clinical outcomes.) | Yes  No | | Intractable ulceration secondary to venous stasis **OR** | Yes  No | | Bleeding varicose vein or if the patient is at high risk of re-bleeding. (i.e. there has been more than one episode of minor haemorrhage or one episode of significant haemorrhage from a ruptured superficial varicosity) **OR** | Yes  No | | Significant and or progressive lower limb skin changes such as Varicose eczema, or lipodermatosclerosis with moderate to severe oedema proven to be caused by chronic venous insufficiency (itching is insufficient for referral) **OR** | Yes  No | | Thrombophlebitis associated with severe and persistent pain requiring analgesia and affecting activities of daily living and or instrumental activities of daily living\* **OR** | Yes  No | | If the patient is severely symptomatic affecting activities of daily living and or instrumental activities of daily living. - **ALL** below must apply:   * Symptoms must be caused by varicosity and cannot be attributed to any other comorbidities or other disease affecting the lower limb. * There must be a documented unsuccessful six month trial of conservative management\*\*   Evidence that symptoms are affecting activities of daily living and/or Instrumental activities of daily living. | Yes  No |   \*Activities of daily living include: functional mobility, eating, bathing and personal care. They can be measured using the Barthel activities of daily living index. Instrumental activities of daily living include more complex tasks such as care of others, community mobility, health management and meal preparation.  \*\* Conservative management should include advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation whenever sitting and weight loss and compression stockings if appropriate.  *If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG’s Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.* |

**PLEASE NOTE:** Secondary Care to reject referral if this form is not complete and return patient to Primary Care.

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| Dear Colleague,  Thank you for kindly seeing this patient.  **Presenting Complaint**    **Relevant Clinical Findings**    **Action to be Taken**    I have attached my recent consultation herewith which is also self-explanatory. I will appreciate your assessment and advice.  Many thanks.  <GP Name> |

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| **\*Interpreter required?** Yes/ No**.**  **If yes, please state which language:** |

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| **MEDICAL HISTORY**   * **History**   Active Problems  <Problems(table)>  Significant Past  <Problems(table)>   * **Last Consultation/s**   <Event Details(table)>   * **Current medication:**   Acute  <Medication(table)>  Repeat  <Medication(table)>   * **Blood Pressure:**   <Last 5 BP Reading(s)(table)>   * **Alcohol Consumption**   <Numerics>   * **Current allergies**   <Allergies & Sensitivities(table)> |

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| **LABORATORY RESULTS (Latest result within last year unless stated)** Lipids   **Glucose / HbA1c** Liver Function TestsRenal / Prostate FunctionHaematologyThyroid FunctionUrinalysisPeak Flow **Histology / ECG / Radiology (Last 2 years)** |