



## Referral

	 <b>Vein Care WA</b>
<b>Date :</b>	
<b>Patient Name :</b> <b>Address:</b>	 <b>South Lake Family Practice</b> <b>Skin &amp; Vein Clinic</b>
<b>Patient Date of Birth :</b>	

Referral to

**Dr Shiva Sethuraman**

*MBBS, FRACGP, MRCGP, MRCS  
Member of Aus College of Phlebology*

### Referral for

Consult & Assessment of patient for - (please tick)

- Varicose Veins**
- Spider Veins**
- Duplex Scan / Ultrasound Scan:**  
**Lower limbs**                      **Others:** \_\_\_\_\_
  - Right**
  - Left**
- Minor Surgery : please specify** \_\_\_\_\_

**Patient History:** \_\_\_\_\_

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**Referring Practitioner:**  
**Provider number & Address:**