**Varicose Vein interventions Referral Proforma**

Individual funding is required prior to any Varicose Vein surgery if a patient does not meet the exceptionality criteria in the Varicose Vein Commissioning policy. It is the responsibility of referring and treating clinicians to ensure compliance with the Varicose Vein Commissioning Policy. Click [here](http://www.newdevonccg.nhs.uk/permanent-link/?rid=102742) to access the policy.

**NOTE for Primary Care Clinician:-**

* Policy criteria **met** as appropriate to intervention complete sections 1-2. Incomplete forms will be returned to the referrer
* Hospital specialist/treating clinician to complete Section 3

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| **Patient Details: Section 1** | | | | | |
| **NHS Number:** |  | **Date of Birth:** |  | | |
| **Surname:** |  | **Title:** |  | | |
| **Forenames:** |  | | | | |
| **Address:** | | | | | |
| **Postcode:** |  | **Email Address:** |  | | |
| **Home Tel No:** |  | **Mobile Tel No:** |  | | |
| **Referring GP Details:** | | | | | |
| **Name:** |  | **Registered GP:** | |  | |
| **Practice:** |  | | | | |
| **Tel No:** |  | **Fax No:** | | |  |

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| **Policy Criteria: Section 2** | | | |
| Treatment for Varicose Veins will not be offered unless the patient meets one of the following referral Criteria:- | | Select boxes as appropriate | |
| A | Patients who have had bleeding associated with varicose veins  Give full clinical detail: *(please enter text below)* | |  |
| Or B | Active leg ulceration  Give full clinical detail: *(please enter text below)* | |  |
| Or C | Patients with recurrent thrombophlebitis and persistent varicose veins  Give full clinical detail: *(please enter text below)* | |  |
| Or D | Patients with eczema near the ankle or associated with varicose veins below the knee.  Give full clinical detail: *(please enter text below)* | |  |
| Or E | Signs of severe venous insufficiency – lipodermatosclerosis or healed ulceration  Give full clinical detail: *(please enter text below)* | |  |

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| **Section 3: For Completion by Hospital Specialist/Treating Clinician** | | |
| I confirm that the patient meets the stated Policy or exceptionality criteria above: | | |
| Name of Hospital Specialist/Treating Clinician |  | Date: |

**Relevant Past Medical History and Medication:**

**Medications**