**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:** | **<NHS number>** | **Date of Birth:** | **<Date of birth>** |
| **Surname:** | **<Patient Name>** | **Title:** | **<Patient Name>** |
| **Forenames:** | **<Patient Name>** |
| **Address:****<Patient Address>** |
| **Postcode:**  | **<Patient Address>** | **Mobile Tel No:**  | **<Patient Contact Details>** |
| **Home Tel No:**  | **<Patient Contact Details>** | **Home Tel No:**  | **<Patient Contact Details>** |
| **Referring GP Details:** |
| **Name:** | **<Sender Name>** | **Registered GP:** | **<GP Name>** |
| **Practice:** | **<Organisation Address>** |
| **Tel No:** | **<Organisation Details>** | **Fax No:** | **<Organisation Details>** |

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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 veinsGive full clinical detail: *(please enter text below)* | [ ]  |
| Or B | Active leg ulcerationGive full clinical detail: *(please enter text below)* | [ ]  |
| Or C | Patients with recurrent thrombophlebitis and persistent varicose veinsGive 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 ulcerationGive 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:**

<Problems(table)>

**Medications**

 **Repeat Medication:**

<Medication(table)>

**Acute Medication:**

<Medication(table)>