Wound & Oedema Clinic

YARRA VASCULAR

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Private Health: _____ Medicare: _____

☐ **Wound** ☐ **Oedema**

Lower Limb: ☐ **Left Leg** ☐ **Right Leg** ☐ **Bilateral Leg**

Duration of Symptoms:

☐ **2 - 6 weeks** ☐ **Greater than 6 weeks**

Clinical Details:

Relevant Previous Investigations:

Relevant Past History:

Referring Doctor Name: _____

Doctor Phone: _____

Provider Number: _____

Date of Referral: _____

Signature: _____

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Suite 6, Level 2
12 Osburn Place
EPPING VIC 3076

Martin Medical
Suite 3, Level 3
10 Martin Street
HEIDELBERG VIC 3084

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