1588093509

# Initial Consultation Form

**To be completed by the trial co-ordinator for every AAA patient referred whether or not they are presently known to be suitable for the EVAR Trials**

**Forename**

**Surname**

**Address**

**Please ensure you have entered the postcode**

**Home telephone number (including std code)**

**Date of birth (patients ≥ 60 years can be included)** / / 

**Patient sex**

**Male** ☐ **Female** ☐

**GP name**

**GP Address**

**GP telephone number (including std code)**

**Regional Hospital** _____

**Regional hospital code**

**Regional Consultant** _____

**Date of referral for EVAR suitability** / /

**Source of referral for suitability for an EVAR device (Please tick one)**

**Existing patient under regular follow up** ☐
**Supporting hospital** ☐ ==>
**Direct GP referral** ☐
**Population screening programs** ☐
**Other regional hospital clinic** ☐
**Accident & Emergency** ☐
**Other and unknown** ☐

**Name of supporting hospital**

**Ultrasound AP diameter (if applicable)** . cm

*CT performed if ultrasound diameter ≥ 5.0cm*

**EVAR study number allocated by Louise Brown**

**Please fax to Louise Brown on 020-8846-7318 for a number to be allocated**