BRONTE VASCULAR ULTRASOUND

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Vascular Surgery

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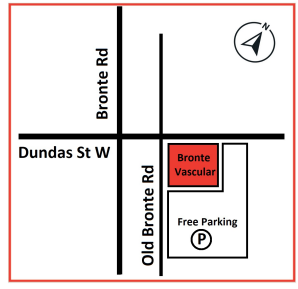

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NAME _____ TEL # _____

OHIP No: _____ D. O. B. _____

REQUEST FOR ASSESSMENT

PERIPHERAL ARTERIAL

- ❒ Carotids
- ❒ Aorta & iliacs (AAA Screening)
- ❒ Lower extremities bilateral (Incl. Aorta, iliacs, ABI, TBI)
- ❒ Renal Duplex
- ❒ Upper extremities bilateral
- R ❒ L ❒ Lower extremity unilateral
- ❒ ❒ Upper extremity unilateral

PERIPHERAL VENOUS

- ❒ Lower extremities bilateral (with insufficiency & IVC & iliacs)
- ❒ Rule-out DVT legs bilateral (inc IVC & iliacs)
- R ❒ L ❒ Rule-out DVT leg unilateral (inc IVC & iliacs)
- ❒ ❒ Upper extremity unilateral

Other: _____

_____

❒ **CLINICAL CONSULTATION REQUEST IF ABNORMAL**

Clinical Information _____

_____

_____

Appointment time: _____ URGENT: ❒

Referring Doctor: _____ Billing #: _____

Clinic: _____ Ph: _____ Fax: _____

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