UNITED IMAGING
CONSULTANTS

Arterial Bypass or Dialysis Fistula Ultrasound

Exam Date		Room #	
Tech Name		Tech Phone	
Ordering MD Name		Ordering MD Phone	
Nurse Name		Nurse Phone	

Patient Name	
DOB	
MR#	
(Sticker OR Fill-out)	

Exam Indication:_____

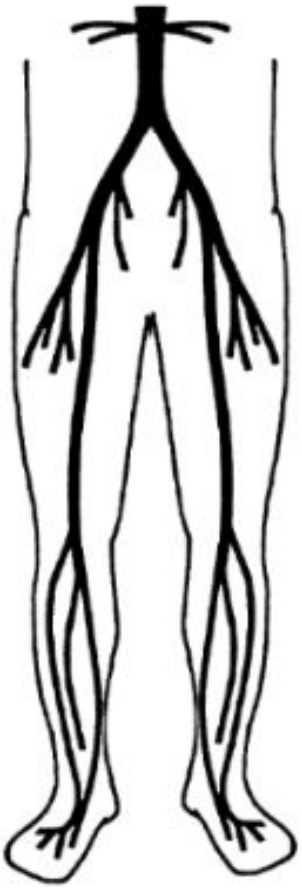
Risk Factors										
O Diabetes	O Stroke	O HTN	O Hx PAD	O Hyperlipidemia	O Smoking	O Hx Vasc Surg	O CAD	O Coagulopathy	O Family Hx	O Obesity

Clinical History					
O Claudication R / L	O Rest Pain R / L	O Hemorrhage	O Trauma	O Cold Limb L / B	O Abnl Pulses L / R
O Embolization R / L	O Ulcer/Wound R / L	O F/U Vasc Surg/Procedure	O Pre-op	O F/U known PAD	O Cyanosis L / R
O Aneurysm	O Pseudoaneurysm	O Dialysis Fistula	O Synthetic Vein Graft	O Vein Graft	O PVD Unspecified
O Details/Other:					

Doppler Findings (**Note direction of flow in the distal native vessel**)

Graft or Fistula #1	Phasicity (circle)	PSV	EDV
Prox Native: _____	tri bi mono		
Prox Anas	tri bi mono		
Prox Graft	tri bi mono		
Mid Graft	tri bi mono		
Dist Graft	tri bi mono		
Dist Anas	tri bi mono		
Dist Native: _____	tri bi mono		

Graft or Fistula #2	Phasicity (circle)	PSV	EDV
Prox Native: _____	tri bi mono		
Prox Anas	tri bi mono		
Prox Graft	tri bi mono		
Mid Graft	tri bi mono		
Dist Graft	tri bi mono		
Dist Anas	tri bi mono		
Dist Native: _____	tri bi mono		



Notes and/or Other Drawings
(Ex: Upper Extremity Bypass/Fistula)