UNITED IMAGING
CONSULTANTS

Lower Extremity Vein Mapping

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)	

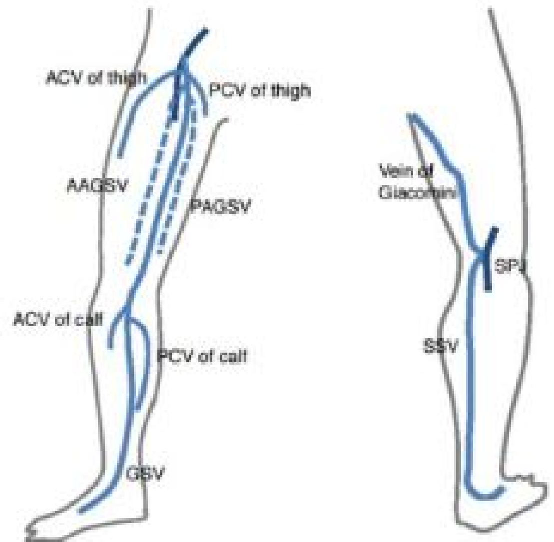
Indication/Clinical History				
O CAD	O Prior DVT R / L / B	O Pre-op Autologous Vein Bypass	O Prior Vasc Surgery R / L / B	O Prior Vein Ablation R / L
O PAD R / L / B	O Ulcer/Wound R / L / B	O Prior Vein Ablation R / L	O Pulmonary Embolism	O Pre-op
O Details/Other:				

Findings: **Always Note Patency, Axial Diameter and Distance from the Skin**

N = Normal P = Partial Thrombus O = Occlusive Thrombus WT = Wall Thickening C = Calcifications

Drawing

RIGHT	GSV			SSV		
Level	Pat	Dia. (mm)	Skin (mm)	Pat	Dia. (mm)	Skin (mm)
Origin						
High Thigh						
Mid Thigh						
Low Thigh						
Knee						
High Calf						
Mid Calf						
Low Calf						



LEFT	GSV			SSV		
Level	Pat	Dia. (mm)	Skin (mm)	Pat	Dia. (mm)	Skin (mm)
Origin						
High Thigh						
Mid Thigh						
Low Thigh						
Knee						
High Calf						
Mid Calf						
Low Calf