

Exam Date		Room #		Patient Name	
Tech Name		Tech Phone		DOB	
Ordering MD Name		Ordering MD Phone		MR#	
Nurse Name		Nurse Phone		(Sticker OR Fill-out)	

Exam Indication: _____

Clinical History					
<input type="checkbox"/> Edema R / L	<input type="checkbox"/> Prior DVT R / L	<input type="checkbox"/> Hypercoagulable	<input type="checkbox"/> Prior Surgery R / L	<input type="checkbox"/> Numb/Paresthesia R / L	<input type="checkbox"/> Pre - Op
<input type="checkbox"/> Pain R / L	<input type="checkbox"/> Ulcer/Wound R / L	<input type="checkbox"/> Temp Change R / L	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Positive Homan's R / L	
<input type="checkbox"/> Details/Other:					

Findings:

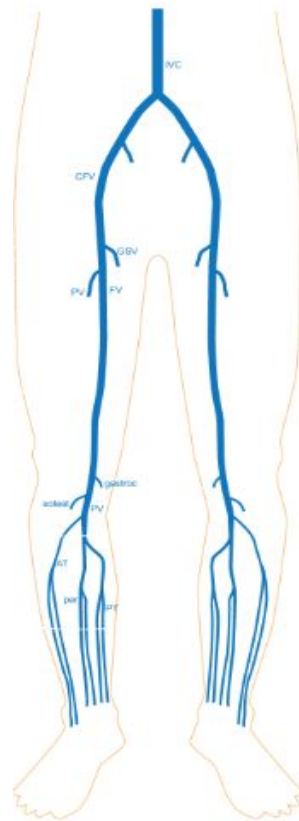
Always Assess Contralateral CFV for unilateral Exams

N = Normal

P = Partial Thrombus

O = Occlusive Thrombus

Drawing



Drawing

Vein	Clot	+/- Comp	+/- Condition
CFV		+ / -	Phasic + / -
Sapheno Femoral jxn		+ / -	
Prox Profunda		+ / -	
Prox Femoral		+ / -	
Med Femoral		+ / -	
Distal Femoral		+ / -	
Popliteal		+ / -	Augmentable + / -
PT			
Peroneal			
AT			

+/- Condition	+/- Comp	Clot	Vein
Phasic + / -	+ / -		CFV
	+ / -		Sapheno Femoral jxn
	+ / -		Prox Profunda
	+ / -		Prox Femoral
	+ / -		Med Femoral
	+ / -		Distal Femoral
Augmentable + / -	+ / -		Popliteal
			PT
			Peroneal
			AT

Describe Clot: Chronic, Subacute, Acute

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Notes: _____
