

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)	

Indication/Clinical History				
<input type="checkbox"/> CAD	<input type="checkbox"/> Prior DVT R / L / B	<input type="checkbox"/> Pre-op Autologous Vein Bypass	<input type="checkbox"/> Prior Vasc Surgery R / L / B	<input type="checkbox"/> Prior Vein Ablation R / L
<input type="checkbox"/> PAD R / L / B	<input type="checkbox"/> Ulcer/Wound R / L / B	<input type="checkbox"/> Prior Vein Ablation R / L / B	<input type="checkbox"/> Pulmonary Embolism	
<input type="checkbox"/> Details/Other:				

Findings:

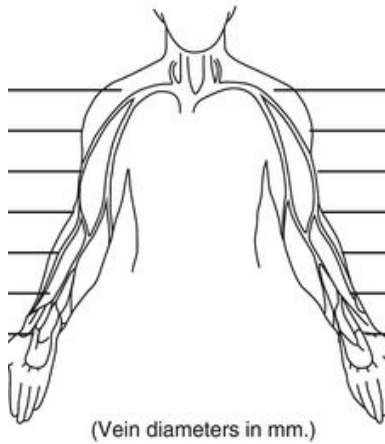
Always Note Patency, Axial Diameter and Distance from the Skin

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

Drawing

Drawing

Level	Cephalic			Basilic		
	Pat	Dia. (mm)	Skin (mm)	Pat	Dia. (mm)	Skin (mm)
High Arm						
Mid arm						
Low Arm						
Antecub						
Upper Forearm						
Forearm						
Wrist						



Skin (mm)	Dia. (mm)	Pat	Cephalic			Level
			Skin (mm)	Dia. (mm)	Pat	
						High Arm
						Mid arm
						Low Arm
						Antecub
						Upper Forearm
						Forearm
						Wrist

Notes:
