UNITED IMAGING
CONSULTANTS

Upper Extremity Venous 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:_____

Clinical History					
O Edema R / L	O Prior DVT R / L	O Hypercoagulable	O Prior Surgery R / L	O Numb/Paresthesia R / L	
O Pain R / L	O Ulcer/Wound R / L	O Temp Change R / L	O Pulmonary Embolism	O Pre-op	
O Details/Other:					

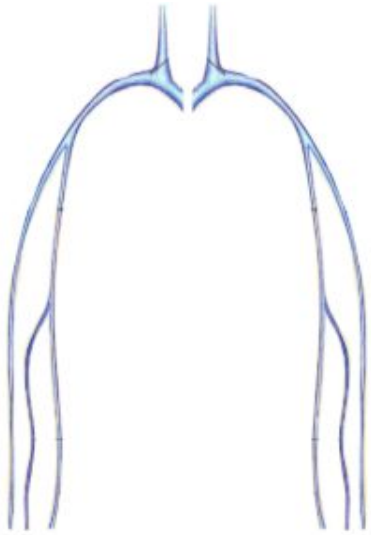
Findings:

Always Assess Contralateral IJ and Subclavian Veins for Unilateral Exams

N = Normal **P = Partial Thrombus** **O = Occlusive Thrombus**

Drawing **Drawing**

Vein	Clot	Phasic	+/- Comp
IJ		+ / -	+ / -
Subclavian		+ / -	+ / -
Axillary		+ / -	+ / -
Brachial		+ / -	+ / -
Basilic above Ante Fossa		+ / -	+ / -
Cephalic Above Ante Fossa		+ / -	+ / -



+/- Comp	Clot	Phasic	Vein
+ / -		+ / -	IJ
+ / -		+ / -	Subclavian
+ / -		+ / -	Axillary
+ / -		+ / -	Brachial
+ / -		+ / -	Basilic above Ante Fossa
+ / -		+ / -	Cephalic above Ante Fossa

Describe Clot: Chronic, Subacute, Acute

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Notes:_____