

VASCULAR ULTRASOUND

All requisitions must be faxed to

PATIENT INFORMATION

| | PLACE | PATIENT | LABEL | HERE |
|--|-------|---------|-------|------|
|--|-------|---------|-------|------|

| PLACE PATIENT LABEL HERE | | | | Home Phone: | | | | |
|-------------------------------------|-----------|-------------------|--|-------------|--|--|--|--|
| Date of Request: <u>D/ M/</u> Name: | | Y/ Female Male | Other Phone: Date of Birth: <u>D/ M/ Y/</u> AHC or WCB #: Physician's Name: | | | | | |
| City: | Province: | Postal Code: | | Prac. ID #: | | | | |
| PROFESSIONAL SERVICES | | | | | | | | |

Head and Neck

Carotid Doppler Incl. Vert/SCA Include IMT Temporal Arteries Thoracic Outlet Syndrome

Abdominal Assessment

Liver Transplant Doppler Mesenteric Vessels Renal Artery Doppler Renal Transplant

Venous Assessment

Venous (DVT) R L Arm Leg Venous Insufficiency (referral from vein specialist/ vascular surgeon required) R 1 Bilateral

Peripheral Arterial Assessment

ABI +/- TBI Only Aorta and Iliac Assessment Duplex Lower Extremity w/ ABI +/- TBI R L Dedicated Tibial Arterial Assessment Duplex Upper Extremity R L LE Segmental Pressures w/TBI R L Popliteal Artery Entrapment Syndrome Raynauds Assessment UE LE

Graft/Stents

Bypass Graft Endovascular Graft/Stent PTA EVAR Surveillance Hemodialysis Fistula/Graft Indicate site of the above:

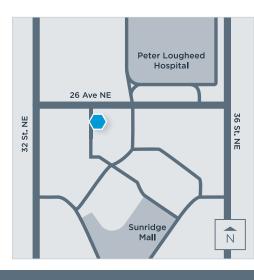
Other

Specify area to be assessed:

HISTORY

Please complete this section with as many details as possible, this enables our clinic staff to provide the most comprehensive patient care.

APPOINTMENT DATE AND LOCATION



MAYFAIR® DIAGNOSTICS

Sunridge Plaza 150, 3363 - 26th Avenue NE Monday to Friday 8 a.m. - 4 p.m.

For more requisition forms please email bd@radiology.ca.

VASCULAR SURGEON APPOINTMENT DATE:

URGENT: Within 48 hours

Within one week pre-angio

OTHER SPECIALIST APPOINTMENT DATE: