

# VASCULAR ULTRASOUND

**PLEASE INCLUDE ALL RELEVANT CHART NOTES**

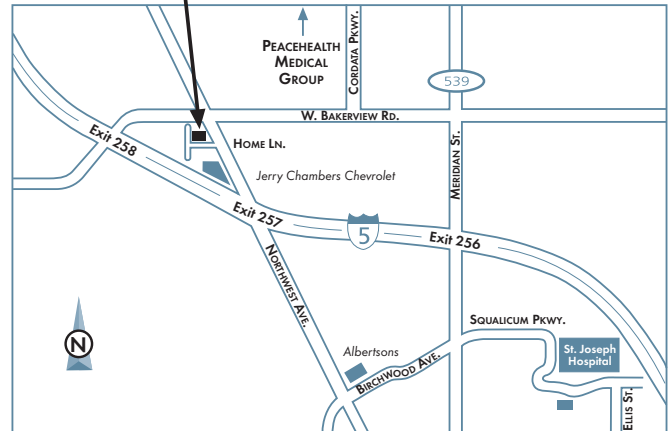
## APPOINTMENT INFORMATION

Appointment Date: \_\_\_\_\_  
 Check-in Time: \_\_\_\_\_  
 Appointment Time: \_\_\_\_\_

See Location Map



**Northwest Avenue**  
 4029 Northwest Avenue,  
 Suite 201



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## PATIENT INFORMATION (please print)

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Telephone(s): \_\_\_\_\_  
 Referring M.D.: \_\_\_\_\_  
 CC: \_\_\_\_\_  
 Insurance Company (s): \_\_\_\_\_  
 Patient's Insurance ID #: \_\_\_\_\_

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## EXAM REQUESTED

### Abdominal Exams (All require fasting):

- Abdominal Aortoiliac Complete       Renal Duplex Doppler  
 Mesenteric Duplex Doppler Complete       Transjugular Intrahepatic Portosystemic Shunt (TIPS)

**Transplant:**  Liver Transplant Duplex Doppler       Renal Transplant Duplex Doppler

### Peripheral Arterial:

- Lower Extremity ABI Bilateral (Ankle Brachial Indices)       Cold Sensitivity / please indicate:  
 Lower Extremity Duplex Bilateral (**Requires fasting**)       Lower Extremity     Upper Extremity  
 Lower Extremity Duplex Unilateral (**Requires fasting**)       Upper Extremity Duplex Bilateral  
 Lower Extremity Stress Test Bilateral (Treadmill Test & ABI)       Thoracic Outlet Syndrome  
 Upper Extremity Duplex Unilateral

### Peripheral Venous:

- Lower Extremity Duplex Bilateral       Upper Extremity Duplex Bilateral  
 Lower Extremity Duplex Unilateral       Upper Extremity Duplex Unilateral

### Cerebrovascular:

- Carotid Duplex Bilateral

### Hemodialysis:

- Hemodialysis Access Duplex

**Other (please specify):** \_\_\_\_\_

Please follow these instructions to ensure a successful ultrasound exam. See specific exam to the left to determine the need for fasting.

### PATIENT PREP FOR FASTING EXAMS

- FAST** 8 hours prior to exam
- NO** smoking or chewing gum prior to exam
- ALL** Patients may take a.m. medications with a small amount of water

### ABDOMINAL & LOWER EXTREMITY ARTERIAL EXAM PREP

The evening prior to your exam **DO NOT** eat, drink, chew gum or smoke after 10 p.m. You will be fasting until after your exam.

**Fax This Referral To: 360-255-2263**

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## CLINICAL SYMPTOMS (required; must have a sign, symptom or known diagnosis. No "Rule Out" or "Follow-Up" )

\_\_\_\_\_

**X**

Physician Signature Required

### Stat Report Desired (choose one)

- Fax Report (Fax number required) \_\_\_\_\_  
 Call Report (Provider cell phone number required) \_\_\_\_\_