

Patient Name: _____ DOB: _____

MRN: _____ **MUST Indicate ICD9 Code:** _____

Referring Physician: _____ Telephone: _____

Address: _____ Fax: _____

Date of Appointment: _____

	Completed
Ultrasound	<input type="checkbox"/>
ABI/PVR (NIFS)	<input type="checkbox"/>

***Note: Patient coming for Aorta, Iliac, Renal, Mesenteric or IVC Duplex MUST fast 8 hrs. prior to the study.**

Physiological Testing with Doppler (NIFS)	Bilateral	Right	Left
<input type="checkbox"/> ABI/PVR Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ABI/PVR Lower Extremities w/exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PVR/Segmental Pressures/Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Digital ___ Upper Extremities ___ Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Allen Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Raynaud's Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Outlet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Arterial Duplex Study (Ultrasound)	Bilateral	Right	Left
<input type="checkbox"/> Carotid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Extremity Arterial Duplex (native vessels)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Popliteal Artery Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Extremity Arterial Duplex (native vessels)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bypass Graft Surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AVF Study/Dialysis Access Graft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Groin Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aorto-Iliac Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AAA w/endo-graft Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Iliac Artery Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Celiac/Mesenteric Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal Artery Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Venous Duplex Study (Ultrasound)	Bilateral	Right	Left
<input type="checkbox"/> Lower Extremity Venous Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Extremity Venous Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vein Mapping Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vein Mapping Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IVC and Iliac Vein Duplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indication/Reason For Study
<input type="checkbox"/> Aneurysm
<input type="checkbox"/> Bruit
<input type="checkbox"/> Claudication
<input type="checkbox"/> Dialysis Access Creation
<input type="checkbox"/> Dissection
<input type="checkbox"/> DVT
<input type="checkbox"/> Edema
<input type="checkbox"/> Gangrene
<input type="checkbox"/> Gait abnormal/lack of coordination
<input type="checkbox"/> IVC Filter Placement
<input type="checkbox"/> Pain in Limb
<input type="checkbox"/> Patency
<input type="checkbox"/> Port Access
<input type="checkbox"/> Post-op Evaluation of _____
<input type="checkbox"/> Pre-op Evaluation for _____
<input type="checkbox"/> Pseudoaneurysm/AVF/Injury
<input type="checkbox"/> PVD/PAD
<input type="checkbox"/> Reflux/ Insufficiency
<input type="checkbox"/> Rest Pain
<input type="checkbox"/> S/P Angioplasty/Atherectomy
<input type="checkbox"/> S/P Endovenous Laser Treatment
<input type="checkbox"/> Stenosis
<input type="checkbox"/> Swelling of Limb
<input type="checkbox"/> Syncope/Collapse
<input type="checkbox"/> TIA
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Other: _____

Misc Study: _____