HAMILTON VASCULAR LAB

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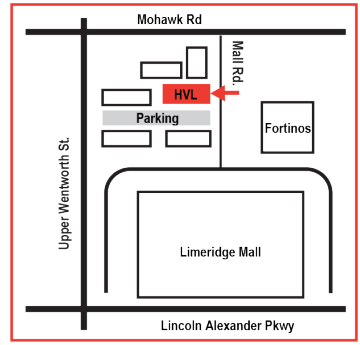

NAME _____ PT. TEL # _____

OHIP No: _____ D. O. B. _____

REQUEST FOR ASSESSMENT

PERIPHERAL ARTERIAL

- ☐ Carotids
- ☐ Aorta & iliac (Aneurysm Screening)
- ☐ Lower extremities bilateral (Incl. Aorta, iliacs, ABI, TBI)
- ☐ Upper extremities bilateral
- R L ☐☐ Lower extremity unilateral
- ☐☐ Upper extremity unilateral

PERIPHERAL VENOUS

- ☐ Lower extremities bilateral (with IVC & iliacs)
- ☐ Upper extremities bilateral
- R L ☐☐ Lower extremity unilateral
- ☐☐ Upper extremity unilateral

Other: _____

☐ CLINICAL CONSULTATION

☐ AV DIALYSIS GRAFT EXAM

Clinical Information _____

_____

_____

Appointment time: _____

Referring Doctor: _____ Billing #: _____

Clinic: _____ Ph: _____ Fax: _____

PRINT RESET