HAMILTON VASCULAR LAB

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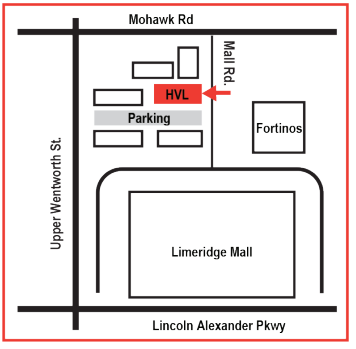

NAME _____ PT. TEL # _____

OHIP No: _____ D. O. B. _____

REQUEST FOR ASSESSMENT

PERIPHERAL ARTERIAL

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

PERIPHERAL VENOUS

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

❒ **CLINICAL CONSULTATION** Other: _____

Clinical Information _____

_____

_____

Appointment time: _____

Referring Doctor: _____ Billing #: _____

Clinic: _____ Ph: _____ Fax: _____

www.hamiltonvascularlab.ca