

VASCULAR ULTRASOUND LAB REQUISITION

CR#: _____ Sex: Female Male
 Name (Last, First): _____
 Health Card # _____
 Date of Birth: _____ Age: _____
 Address: _____
 Phone: (Home) _____ (Work) _____



Fax: 613-548-1339
 KGH Site
 Tel: 613-549-6666 Ext: 3050

INPATIENT <input type="checkbox"/>	ER/UCC <input type="checkbox"/>	OUTPATIENT <input type="checkbox"/>	Patient in Isolation: NO <input type="checkbox"/> YES <input type="checkbox"/> (Specify type: _____)
Service: _____			Patient Transport: Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input type="checkbox"/>
Floor/Section: _____		Room #: _____	Bed <input type="checkbox"/> O2 <input type="checkbox"/>

EXAMINATION REQUESTED	INDICATION/HISTORY	
VASC US CAROTID <input type="checkbox"/> Carotid arteries (includes vertebral arteries) <input type="checkbox"/> Subclavian arteries	<input type="checkbox"/> Claudication <input type="checkbox"/> Tiredness/Numbness <input type="checkbox"/> Ischemic Rest Pain <input type="checkbox"/> Ulceration/ tissue loss <input type="checkbox"/> Varicose veins <input type="checkbox"/> Venous stasis/ulcers <input type="checkbox"/> R/O DVT <input type="checkbox"/> Prior DVT Follow-up <input type="checkbox"/> Venous insufficiency	<input type="checkbox"/> Swelling <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Amaurosis Fugax <input type="checkbox"/> Subclavian steal <input type="checkbox"/> Asymmetric BP <input type="checkbox"/> Other (specify): _____ _____
VASC US EXTREMITY <input type="checkbox"/> Arterial Arms <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Arterial Legs <input type="checkbox"/> ABIs <input type="checkbox"/> Pseudoaneurysm <input type="checkbox"/> Stent/graft/bypass (specify site): _____ follow-up		
VASC US EXTREMITY <input type="checkbox"/> Venous Arms <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Venous Legs <input type="checkbox"/> Stent follow-up		
VASC US ABDOMENAL/PELVIS <input type="checkbox"/> AAA Screening/Follow-up <input type="checkbox"/> Post EVAR Follow-up		
VASC US EXTREMITY <input type="checkbox"/> Dialysis Graft/Fistula <input type="checkbox"/> Venous mapping (pre-fistula)		
<input type="checkbox"/> Other(specify): _____		
Additional Information: _____ _____	Ordering Provider Signature: _____ Name: (Last, First) _____ (printed name) CPSO: _____ Ordering Provider phone/pager# : _____ Attending Physician: _____ Copy Report to: _____ (please print full name) Date requisition complete: _____ YYYY/MM/DD	
Prior Imaging: _____		

Patient Information:

- Test take approximately 60 minutes, please arrive 15 mins prior to your appointment
- Do not smoke/vape/chew gum prior to your test
- Bring your health card
- Directions: Take the main elevators to the 7th floor. Follow signs to the Vascular Lab