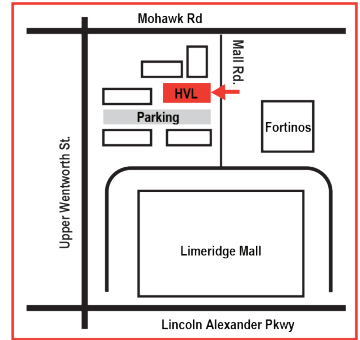




HAMILTON VASCULAR LAB



849 Upper Wentworth Street # 400
Hamilton, ON, L9A 5H4
Tel. 905-538-2260
Fax. 905-538-2262



NAME _____ PT. TEL # _____

OHIP No: _____ D. O. B. _____

REQUEST FOR ASSESSMENT

PERIPHERAL ARTERIAL

- ☐ Carotids
- ☐ Aorta & iliacs (AAA Screening)
- ☐ Lower extremities bilateral
(Incl. Aorta, iliacs, ABI, TBI)
- ☐ Renal Duplex
- ☐ Upper extremities bilateral
- ☐ ^R ☐ ^L Lower extremity unilateral
- ☐ ☐ Upper extremity unilateral

PERIPHERAL VENOUS

- ☐ Lower extremities bilateral
(with insufficiency & IVC & iliacs)
- ☐ Rule-out DVT legs bilateral (inc IVC & iliacs)
- ☐ ^R ☐ ^L Rule-out DVT leg unilateral (inc IVC & iliacs)
- ☐ ☐ Upper extremity unilateral

Other: _____

☐ CLINICAL CONSULTATION REQUEST IF ABNORMAL

Clinical Information _____

Appointment time: _____ URGENT: ☐

Referring Doctor: _____ Billing #: _____

Clinic: _____ Ph: _____ Fax: _____

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