Scarborough Vascular Ultrasound

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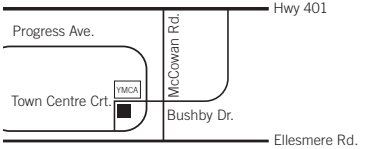

PATIENT INFORMATION

PLEASE BRING YOUR HEALTH CARD WITH YOU

Health Card No. _____

Surname _____ First name _____

DOB d_____ m_____ y_____ ☐ Male ☐ Female

City _____ Postal Code _____

Home Phone _____

Business Phone _____

REFERRING PHYSICIAN

Clinical Priority: Urgent (<24 hrs) ☐ Semiurgent (< 1 wk) ☐ Elective ☐

Fax/Emergency Telephone Number _____

Copy to _____

Clinical History/Follow-up Frequency _____

_____

_____

Name of Doctor _____

Signature

VASCULAR ULTRASOUND

Appointment Time:

Renal Arteries ☐
Abdominal Aorta ☐

Do not eat 6 hours before your exam. Drink 6 glasses of water 1 hour before your appointment. Do not go to the bathroom.

NECK

Arterial (Carotids &Vertebrals) ☐
Venous ☐

EXTREMITIES

PERIPHERAL ARTERIAL	LEFT	RIGHT
Arm	☐	☐
Leg	☐	☐
PERIPHERAL VENOUS	**LEFT**	**RIGHT**
Arm	☐	☐
Leg	☐	☐
Superficial Venous (Varicose Veins)	☐	☐
Deep Venous System (DVT)	☐	☐
Dialysis Fistula or Graft	☐	☐
Other: _____	☐	☐