

VASCULAR ULTRASOUND

PLEASE INCLUDE ALL RELEVANT CHART NOTES

APPOINTMENT INFORMATION

Appointment Date: _____

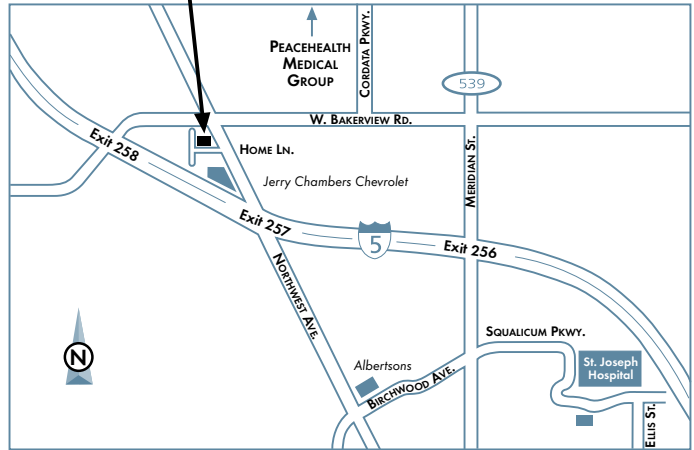
Check-in Time: _____

Appointment Time: _____

See Location Map



Northwest Avenue
4029 Northwest Avenue,
Suite 201



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PATIENT INFORMATION (please print)

Name: _____

DOB: _____

Telephone(s): _____

Referring M.D.: _____

CC: _____

Primary Insurance Name: _____

Comparison Films: Patient Bring Office Will Send None

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EXAM REQUESTED

Abdominal Exams (Fasting):

- | | |
|--|--|
| <input type="checkbox"/> Abdominal Aortic Aneurysm | <input type="checkbox"/> Renal Artery Duplex |
| <input type="checkbox"/> Aortal-iliac Bypass Graft Surveillance | <input type="checkbox"/> Portal-Splenic Vein / TIPPS |
| <input type="checkbox"/> Abdominal Visceral Vasculature Evaluation | |

Peripheral Arterial:

- | | |
|---|--|
| <input type="checkbox"/> Ankle-Brachial Indices | <input type="checkbox"/> Upper Extremity Duplex |
| <input type="checkbox"/> Treadmill Exercise (Fasting) | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Lower Extremity Duplex Bilateral (Fasting) | <input type="checkbox"/> Cold Sensitivity / Raynauds |
| <input type="checkbox"/> Lower Extremity Duplex Unilateral | <input type="checkbox"/> Bypass Graft Surveillance |

Peripheral Venous:

- | | |
|---|---|
| <input type="checkbox"/> Lower Extremity Bilateral | <input type="checkbox"/> Upper Extremity Unilateral |
| <input type="checkbox"/> Lower Extremity Unilateral | <input type="checkbox"/> Upper Extremity Bilateral |
| <input type="checkbox"/> IVC | |

Cerebrovascular:

- Carotid-Vertebral Artery Duplex

Please follow these instructions to ensure a successful ultrasound exam.

PATIENT PREP FOR FASTING EXAMS

1. **FAST** 8 hours prior to exam
2. **NO** smoking or chewing gum prior to exam
3. **ALL** Patients may take a.m. medications with a small amount of water

See back for additional instructions

Fax This Referral To: 360-255-2263

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CLINICAL SYMPTOMS (required; must have a sign, symptom or known diagnosis. No "Rule Out" or "Follow-Up")

X

Physician Signature Required _____

Call Report

Stat Report Desired

Direct line (preferably cell phone) number required _____

ABDOMINAL EXAMS

- The day before your exam follow a low fat diet and avoid gas producing foods (please refer to the “food allowed and to avoid” guidelines listed below).
- The evening before your exam do NOT eat, drink, chew gum or smoke after 10 p.m. You will be fasting until your exam is completed.

GUIDELINES FOR A LOW FAT DIET:

FOODS ALLOWED: Fruit juices (except apple juice), coffee, tea, water, lean beef, fish, lamb, poultry, rice, pasta, fat-free broth-based soups, dry cereals (except bran products), most vegetables, most fruits, Jell-O, and sherbet. All food should be prepared without added fat and should not be fried.

FOODS TO AVOID: Whole milk, apple juice, beer, carbonated beverages, all fried foods, highly spiced foods, dried beans, potatoes, vegetables in the cabbage family, whole grain products, prunes, chocolate.