NORTHWEST RADIOLOGISTS

Scheduling Phone: 360-647-2422
Toll Free: 800-767-0430
Fax This Referral To: 360-255-2263

VASCULAR ULTRASOUND

PLEASE INCLUDE ALL RELEVANT CHART NOTES

APPOINTMENT INFORMATION

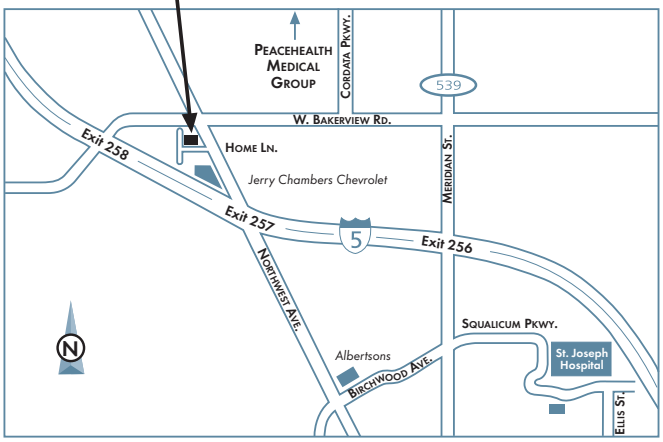
Appointment Date: _____

Check-in Time: _____

Appointment Time: _____

See Location Map

Northwest Avenue
4029 Northwest Avenue,
Suite 201



1 PATIENT INFORMATION (please print)

Name: _____

DOB: _____

Telephone(s): _____

Referring M.D.: _____

CC: _____

Insurance Company (s): _____

Patient's Insurance ID #: _____

2 EXAM REQUESTED

Abdominal Exams (All require fasting):

- ☐ Abdominal Aortoiliac Complete
- ☐ Mesenteric Duplex Doppler Complete
- ☐ Renal Duplex Doppler
- ☐ Transjugular Intrahepatic Portosystemic Shunt (TIPS)

Transplant: ☐ Liver Transplant Duplex Doppler ☐ Renal Transplant Duplex Doppler

Peripheral Arterial:

- ☐ Lower Extremity ABI Bilateral (Ankle Brachial Indices)
- ☐ Lower Extremity Duplex Bilateral **(Requires fasting)**
- ☐ Lower Extremity Duplex Unilateral **(Requires fasting)**
- ☐ Lower Extremity Stress Test Bilateral (Treadmill Test & ABI)
- ☐ Cold Sensitivity / please indicate: ☐ Lower Extremity ☐ Upper Extremity
- ☐ Upper Extremity Duplex Bilateral
- ☐ Thoracic Outlet Syndrome
- ☐ Upper Extremity Duplex Unilateral

Peripheral Venous:

- ☐ Lower Extremity Duplex Bilateral
- ☐ Lower Extremity Duplex Unilateral
- ☐ Upper Extremity Duplex Bilateral
- ☐ Upper Extremity Duplex Unilateral

Cerebrovascular:

- ☐ Carotid Duplex Bilateral

Hemodialysis:

- ☐ Hemodialysis Access Duplex

☐ **Other (please specify):** _____

Please follow these instructions to ensure a successful ultrasound exam. See specific exam to the left to determine the need for fasting.

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

ABDOMINAL & LOWER EXTREMITY ARTERIAL EXAM PREP

The evening prior to your exam DO NOT eat, drink, chew gum or smoke after 10 p.m. You will be fasting until after your exam.

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

_____

X _____
Physician Signature Required

Stat Report Desired (choose one)

- ☐ Fax Report (Fax number required) _____
- ☐ Call Report (Provider cell phone number required) _____