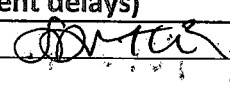



VASCULAR LABORATORY REQUEST FORM

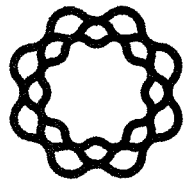
Please fill out or insert patient sticky label, and tick where necessary			
(Please note: ... forms may result in appointment delays)			
SURNAME:	J022600	Referring Consultant:	
FORENAME:	WILLIAMS, Naomi	Referring Doctor:	
Date of Birth:	NHS No: 466 305 3777	Bleep Number:	
MRN:	DOB: 28/07/1933	Date of Referral:	11/1/19
NHS Number:	8 Goldfinch House	Inpatient <input type="checkbox"/>	Outpatient <input type="checkbox"/>
Address:	Larkwood Avenue	Ward and Bed Number:	
	London	Method of Transport:	Bed <input type="checkbox"/> Chair <input type="checkbox"/>
	SE10 8GJ	Oxygen Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Current Infections/Isolation Risks	

Examination(s) required (please circle/tick appropriately):

Venous Doppler Scans			Limb:
Venous Insufficiency	(30mins) Primary Varicose Veins	<input type="checkbox"/>	Left <input type="checkbox"/> Right <input checked="" type="checkbox"/> Both <input type="checkbox"/>
	(45mins) Recurrent Varicose Veins	<input type="checkbox"/>	
	(30mins) Deep Venous Insufficiency	<input type="checkbox"/>	
DVT	(30mins) Post-Phlebotic Syndrome	<input type="checkbox"/>	
	(30mins) Acute DVT Lower / Upper Limb	<input type="checkbox"/>	
Clinical Information:	Varicose Veins <input type="checkbox"/> Ulceration <input type="checkbox"/> Acute Pain <input type="checkbox"/> Swelling <input checked="" type="checkbox"/> Skin Changes <input type="checkbox"/> Previous DVT(s) <input type="checkbox"/> D-Dimer Score <input type="checkbox"/> Previous EVLT (GSV/SSV) <input type="checkbox"/> Previous Stripping (GSV/SSV) <input type="checkbox"/>		
Additional info if possible:			

Arterial Doppler Scans			Limb:
(30mins) ABPI <input type="checkbox"/> (30mins) Exercise Test <input type="checkbox"/>			Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/>
(30mins) Carotid Duplex Scan		<input type="checkbox"/>	
(please provide symptoms of CVA or TIA in addition to risk factors below)			
Abdomen	(30mins) Aortic Duplex Scan	<input type="checkbox"/>	
	(45mins) Renal Arteries Duplex Scan	<input type="checkbox"/>	
Upper Limb Arterial	(30/60mins) Thoracic Outlet Syndrome	<input type="checkbox"/>	
	(30/60mins) Arterial Upper Limb Duplex Scan	<input type="checkbox"/>	
Lower Limb Arterial	(30/60mins) Arterial Lower Limb Duplex Scan	<input type="checkbox"/>	
Please provide info on Known Graft(s) and location(s):			
Clinical Information:	Acute presentation <input type="checkbox"/> Pain <input type="checkbox"/> Pallor <input type="checkbox"/> Pulselessness <input type="checkbox"/> Paresthesia <input type="checkbox"/> Paralysis <input type="checkbox"/> Known PVD <input type="checkbox"/> Intermittent Claudication _____ Yards <input type="checkbox"/> Ulcer <input type="checkbox"/> Diabetic type 1 / type 2 <input type="checkbox"/> Smoker <input type="checkbox"/> IHD <input type="checkbox"/> HTN <input type="checkbox"/>		
Additional info if possible:			

Office use only:	Date Stamp:



Vascular
Solutions

MR PATEL ONE-STOP CL 11/01/2018

Lewisham and Greenwich **NHS**

NHS Trust

Handwritten: Vascular Solutions

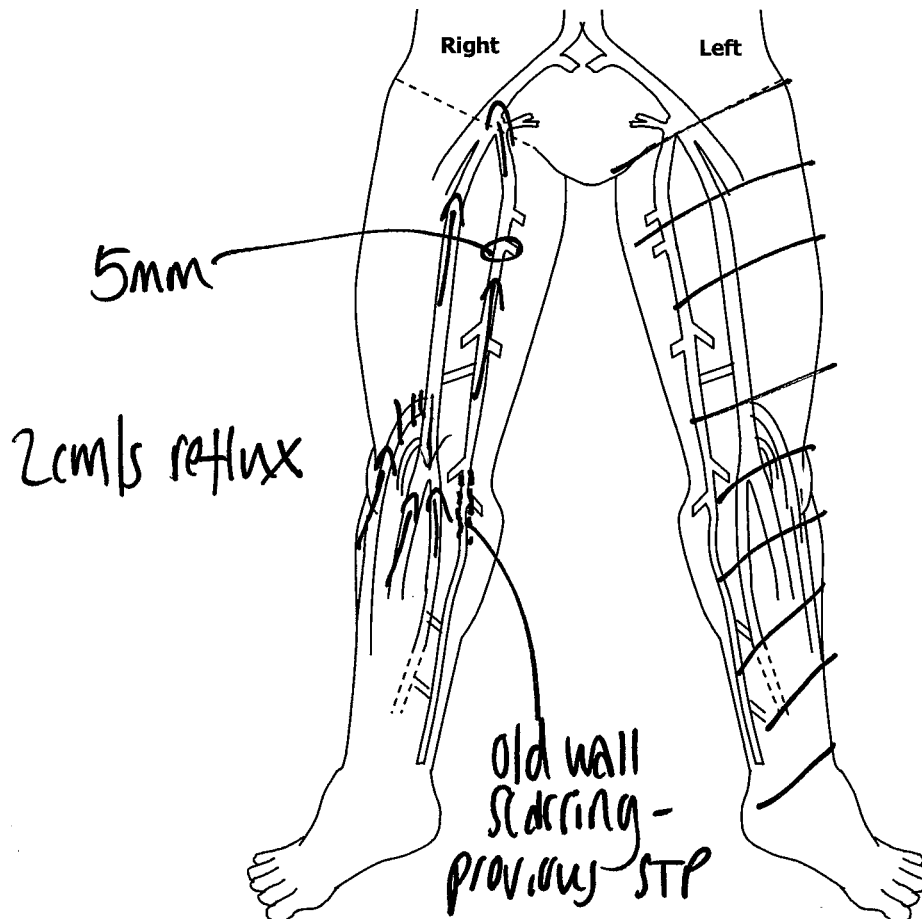
Handwritten: Performed By: Emily Blake (CVS)

~~XXXXXXXXXXXXXXXXXXXX~~
~~XXXXXXXXXXXXXXXXXXXX~~

~~25/07/1933~~

~~XXXXXXXXXXXX~~
~~XXXXXXXXXXXX~~

Handwritten: Patient scanned leaning against exam couch - elderly with limited mobility



*Handwritten: No gross superficial reflux - GSV is dilated but not incompetent.
Reflux detected in distal popv (2cm/s)*