

VASCULAR LABORATORY REQUEST FORM

Please fill out this form, attach patient sticky label, and tick where necessary
Incorrect forms may result in appointment delays)

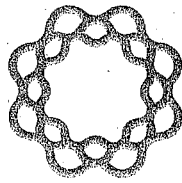
SURNAME:	[REDACTED]	Referring Consultant:	[REDACTED]
FORENAME:		Referring Doctor:	
Date of Birth:		Bleep Number:	
MRN:		Date of Referral:	
NHS Number:		Inpatient <input type="checkbox"/> Outpatient <input checked="" type="checkbox"/>	
Address:		Ward and Bed Number:	
		Method of Transport:	Bed <input type="checkbox"/> Chair <input type="checkbox"/>
		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 type="checkbox"/> Both <input checked="" type="checkbox"/>
	(45mins) Recurrent Varicose Veins	<input type="checkbox"/>	
	(30mins) Deep Venous Insufficiency	<input type="checkbox"/>	
DVT	(30mins) Post-Phlebitic 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 checked="" 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 <small>(please provide symptoms of CVA or TIA in addition to risk factors below)</small>		<input type="checkbox"/>	
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 <small>Please provide info on Known Graft(s) and location(s):</small>	<input type="checkbox"/>	
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:
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Vascular
Solutions

ONE-STOP 7/12/2018

Vascular Lab Report

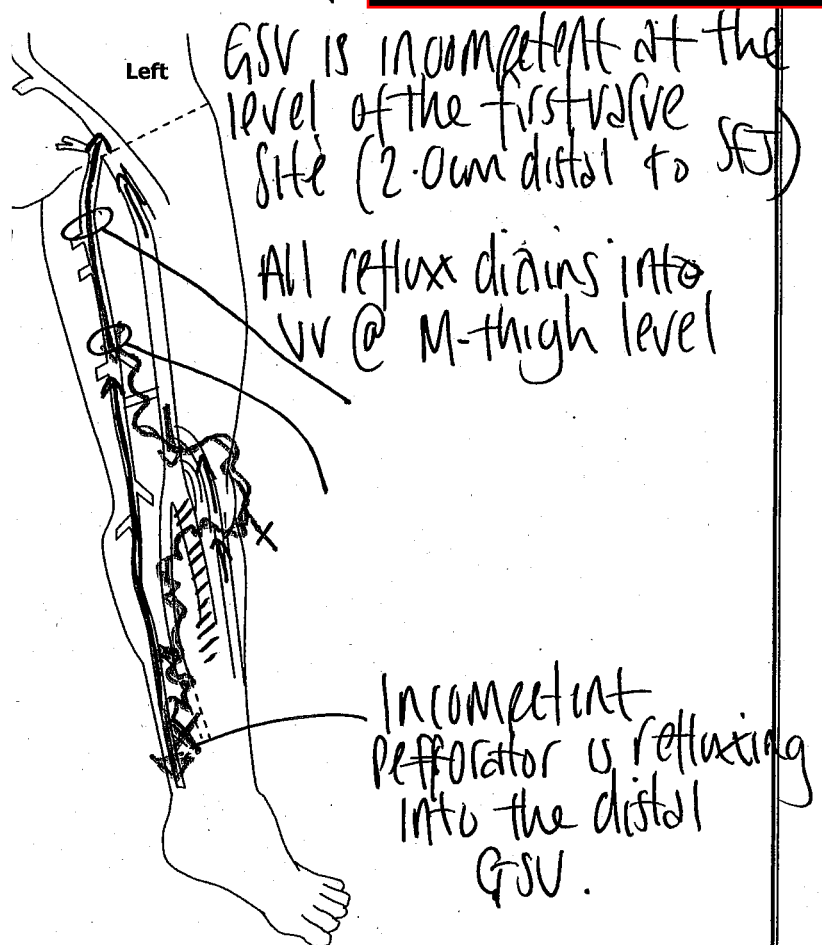
NHS Trust



Assessed by: Emily Blake CVS

Patient scanned leaning against extra couch as unable to stand on the exam steps.

Lower Limb Venous Insufficiency Duplex Scan



Significant POPV reflux
limited assessment of deep
crural veins (PEPVR not