

1A 1A

VASCULAR LABORATORY REQUEST FORM

Please fill out or insert patient sticky label, and tick where necessary (Please note incomplete request forms may result in appointment delays)			
SURNAME:		Referring Consultant:	
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 checked="" 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 checked="" type="checkbox"/> Acute Pain <input type="checkbox"/> Swelling <input 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 (please provide symptoms of CVA or TIA in addition to risk factors below)		<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 Please provide info on Known Graft(s) and location(s):	<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:			

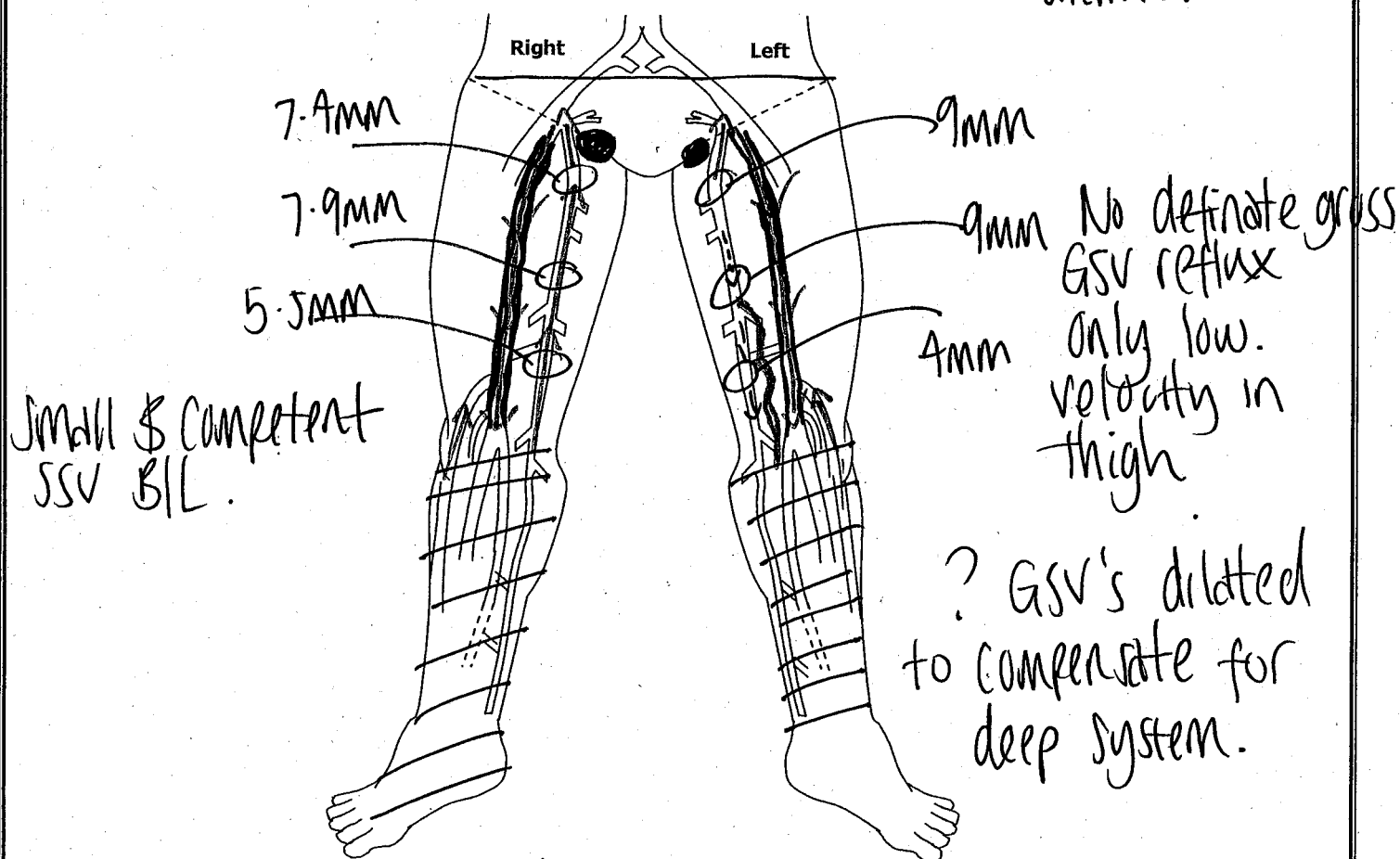
Office use only:	Date Stamp:

-- ONE STOP

Assessed by: Emily Blake CVS

Lower Limb Venous Insufficiency Duplex Scan

Significant reflux in FV / POPV BIL with old residual thrombus, scarring noted throughout. Proximal FV on left = 4mm diameter



(oedema noted at proximal calf level with enlarged lymph node in both groins)