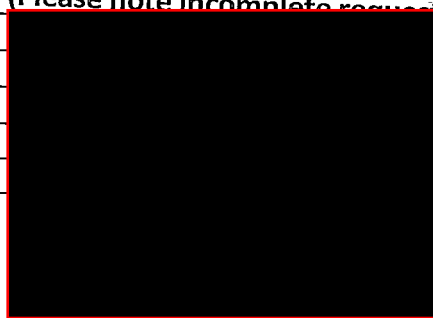
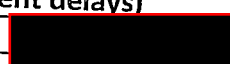


VASCULAR LABORATORY REQUEST FORM

Please fill out or insert patient sticky label, and tick where necessary
(Please note incomplete request forms may result in appointment delays)

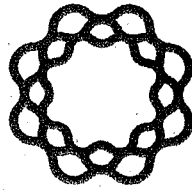
SURNAME:		Referring Consultant:		
FORENAME:		Referring Doctor:		
Date of Birth:		Bleep Number:		
MRN:		Date of Referral:		
NHS Number:		Inpatient <input type="checkbox"/>	Outpatient <input checked="" type="checkbox"/>	
Address:		Ward and Bed Number:		
		Method of Transport:	Bed <input type="checkbox"/>	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 checked="" type="checkbox"/> Right <input type="checkbox"/> Both <input 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 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"/> (30mins) Carotid Duplex Scan <small>(please provide symptoms of CVA or TIA in addition to risk factors below)</small>			Left <input type="checkbox"/> Right <input type="checkbox"/> Both <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:



Vascular
Solutions

NHS

NHS Trust

Vascular lab report

Assessed by: EB

Name: [Redacted]

Hospital No:

Date of Exams: 15/2/2019

DOB: [Redacted]

NHS No:

Ip/Op: One Stop Clinic Suite 4

Referral: [Redacted]

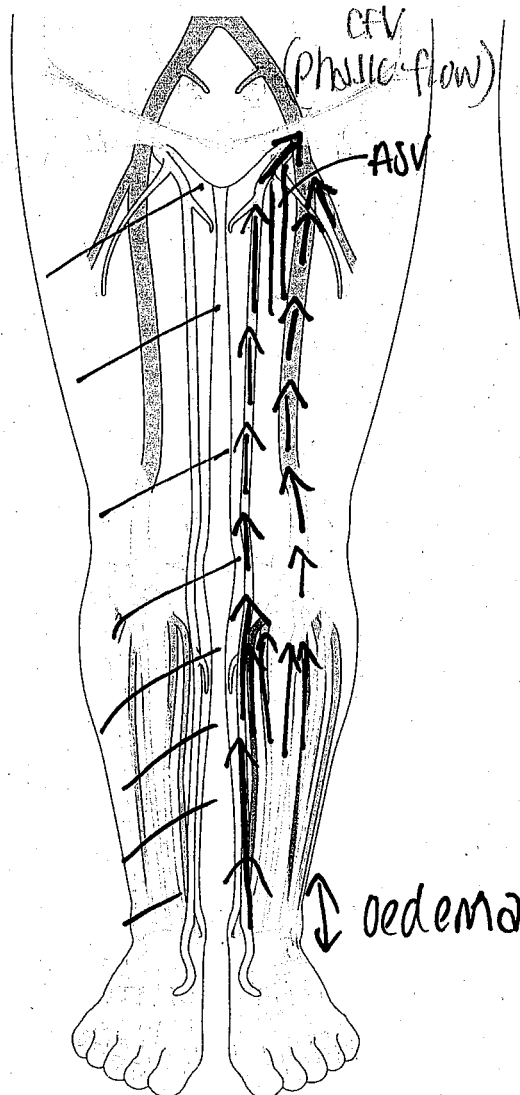
Hospital Site: UHL

Clinical Indications: skin changes / primary VVs

Lower Limb – Venous Insufficiency scan [Both]

Anterior view

Posterior view



LT

No superficial
incompetence.

No fem-pop
reflux - potently
noted throughout
(no swirling)

Cruel veins
difficult to
fully image due
to poor views
but no gross reflux
(within PT/PEROV)



Superficial veins



Deep veins