

# one-stop

## VASCULAR LABORATORY REQUEST FORM

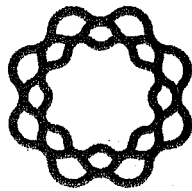
Please fill out or insert patient sticky label, and tick where necessary (Please note incomplete request forms may result in appointment delays)			
SURNAME:	[Redacted]	Referring Consultant:	[Redacted]
FORENAME:		Referring Doctor:	
Date of Birth:		Bleep Number:	
MRN:		Date of Referral:	15/3/19
NHS Number:		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		<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

NHS

NHS Trust

Vascular lab report

Assessed by: EB

Name:

Hospital No:

Date of Exams:

15/3/2019

DOB:

NHS No: A

Ip/Op:

OP one-stop cl.

Referrer:

Hospital Site:

VHL

Clinical Indications:

Swelling / skin changes

Lower Limb -

Anterior view

Posterior view

Mildly dilated  
GSV's  
but no 4mm  
reflux

3.7mm

4mm

4mm

Mild oedema  
in left calf.

No deep vein insuff.



Arrow down and red  
colour denotes reflux



Competent  
superficial vein



Competent  
deep vein