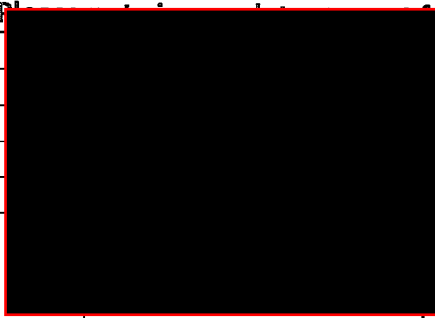


VASCULAR LABORATORY REQUEST FORM

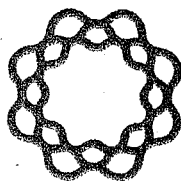
Please fill out or insert patient sticky label, and tick where necessary (Please note that incomplete forms may result in appointment delays)		
SURNAME:		Referring Consultant:
FORENAME:		Referring Doctor:
Date of Birth:		Referral Number:
MRN:		Date of Referral:
NHS Number:		Inpatient <input type="checkbox"/> 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-Phlebotic Syndrome	<input type="checkbox"/>	
	(30mins) Acute DVT Lower / Upper Limb	<input type="checkbox"/>	
Clinical Information:			
Varicose Veins <input checked="" type="checkbox"/> Ulceration <input 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"/> (30mins) Carotid Duplex Scan (please provide symptoms of CVA or TIA in addition to risk factors below)			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:
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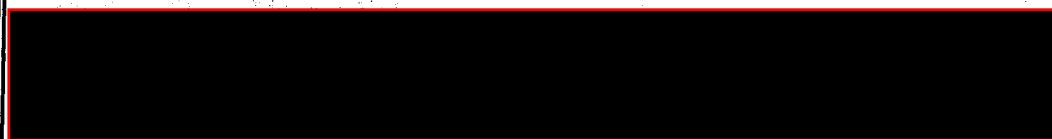


Vascular
Solutions

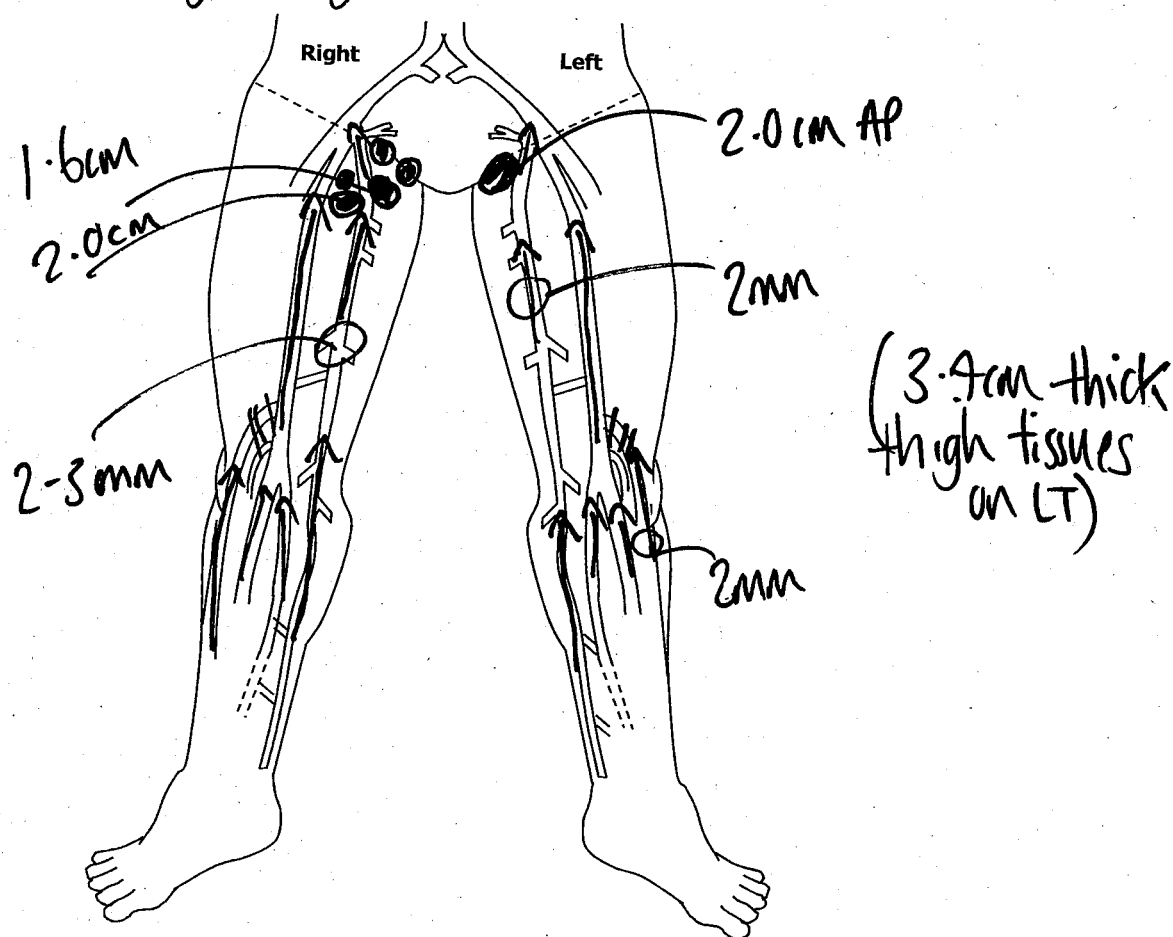
ONE STOP CL [REDACTED] 11/01/2019

NHS

NHS Trust



Multiple reactive groin lymph nodes R > L



Mild oedema noted in both calves. (2cm AP diameter L > R)
No superficial or deep venous insufficiency.