East Toronto Vascular Clinic

# VASCULAR DOPPLER ULTRASOUND REFERRAL FORM

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***Patient Information***

Name: ☐ Male ☐ Female

DOB:

Address:

Patient Phone Number:

Patient Email:

Referring MD:

Health Card #: Family MD:

** At this time we cannot accommodate patients on stretchers, oversized wheelchairs or those that cannot transfer independently

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**VASCULAR SURGERY CONSULT:** ☐ YES, RFR:

☐ IF NONINVASIVE TESTING ABNORMAL

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## VASCULAR DOPPLER ULTRASOUND TESTING

### ARTERIAL TESTING

***Lower Extremity***

☐ Screening / PAD/ Claudication
☐ Rest/night pain
☐ Gangrene/Tissue loss/ulcer
☐ Surveillance / Post op

***Upper Extremity***

☐ Screening
☐ Brachial pressure discrepancy
☐ Digital cyanosis/gangrene

***Abdominal***

☐ Aneurysm – Aortic, Iliac, Visceral
☐ PAD/Stenosis

***Carotid***

☐ Visual Disturbance
☐ TIA/Stroke
☐ Vertigo/Dizziness / Syncope
☐ Screening / Pre-Op
☐ Post-Op
☐ Subclavian stenosis

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### VENOUS

***Lower Extremity***

☐ DVT/Phlebitis
☐ Edema
☐ Varicose Veins/Venous Insufficiency

***Upper Extremity***

☐ DVT
☐ Edema

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### DIALYSIS ACCESS

☐ Pre-op for dialysis access ☐ Post-op/surveillance of access