INSTITUTE FOR VASCULAR TESTING

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*Referred Patient:*_____ *Telephone:*_____

Date of Birth: _____ *Referring Physician Telephone/Fax:* _____

Referring Physician: _____ *Date:* _____

CEREBROVASCULAR TESTING:

_____*Carotid/Vertebral Duplex*

ARTERIAL TESTING:

_____*(ABI) Lower Extremity Screening*
_____*Lower Extremity Arterial*
_____*(Claudication/PAD)*
_____*Lower Extremity Duplex*
_____*(Aneurysm/Bypass graft)*
_____*Upper Extremity Evaluation*

ABDOMINAL VASCULAR EVALUATION:

_____*AAA/ Aorto-Iliac*
_____*Renal Artery*
_____*Mesenteric/Portal*
_____*Renal/Liver Transplant*

VENOUS TESTING:

_____*Venous Obstruction (r/o DVT)*
_____*Lower Extremity R L*
_____*Upper Extremity R L*
_____*Reflux/Insufficiency R L*
_____*Venous Mapping*
_____*Lower Extremity R L*
_____*Upper Extremity R L*

ANCILLARY TESTING:

_____*Hemodialysis Access*
_____*Radial Artery/Allen's Testing*
_____*Raynaud's Testing*
_____*Lower Extremity*
_____*Upper Extremity*

_____**SCREENING (***check here to include all 3)*
_____*Stroke*
_____*AAA*
_____*PAD*

_____**VENOUS THROMBOSIS/BLOOD CLOT MANAGEMENT** *(Acute Lovenox Administration, anticoagulation instruction and management as desired by referring physician)*

INDICATIONS FOR REQUESTED TESTING: _____

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All Vascular exams are performed by an experienced Registered Vascular Technologist and interpreted by a qualified Registered Physician Vascular Interpreter.

IVT Technical Director: Debbie Hoover, RVT RDMS