HAMILTON VASCULAR LAB

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ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

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PATIENT'S NAME _____ D. O. B. _____

OHIP # _____ DATE _____

Phone # _____

PERIPHERAL ARTERIAL

- ☐ Carotids
- ☐ Lower extremities bilateral (Incl. Aorta, ABI, TBI)
- ☐ Upper extremities bilateral

PERIPHERAL VENOUS

- ☐ Lower extremities bilateral (Incl. IVC)
- ☐ Upper extremities bilateral
- ☐ Rule out DVT
- ☐ Venous Mapping

☐ **CLINICAL CONSULTATION**

☐ **AV DIALYSIS GRAFT EXAM**

☐ **OTHER** _____

Clinical Information _____

_____

Referring Doctor: _____ Billing #: _____

Clinic: _____ Ph: _____ Fax: _____

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