



# HAMILTON VASCULAR LAB

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## LABORATORY 1

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## LABORATORY 2

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NAME \_\_\_\_\_ PT. TEL # \_\_\_\_\_

OHIP No: \_\_\_\_\_ D. O. B. \_\_\_\_\_

## REQUEST FOR ASSESSMENT

### PERIPHERAL ARTERIAL

- Carotids
- Aorta & iliac (Aneurysm Screening)
- Lower extremities bilateral  
(Incl. Aorta, iliacs, ABI, TBI)
- Upper extremities bilateral
- <sup>R L</sup>  
 Lower extremity unilateral
- Upper extremity unilateral

### PERIPHERAL VENOUS

- Lower extremities bilateral  
(with IVC & iliacs)
- Upper extremities bilateral
- <sup>R L</sup>  
 Lower extremity unilateral
- Upper extremity unilateral

Other: \_\_\_\_\_

### CLINICAL CONSULTATION

### AV DIALYSIS GRAFT EXAM

Clinical Information \_\_\_\_\_

\_\_\_\_\_

Appointment time: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Billing #: \_\_\_\_\_

Clinic: \_\_\_\_\_ Ph: \_\_\_\_\_ Fax: \_\_\_\_\_