

Patient Details	Referring Doctor
UR:	Name:
Name:	Provider No.:
Gender: Male / Female	Telephone:
DOB: / /	Address:
Telephone:
Mobile:
Address:	Signature:
.....	Date: / /
.....	

Report Destination (please circle)

Routine: Telephone:

Fax to: Email to:

Investigation Requested			
<p style="text-align: right;"><i>Please tick</i></p> <p>1. Carotid <input type="checkbox"/></p> <p>2. Mesenteric Arteries <input type="checkbox"/></p> <p>3. Aorta <input type="checkbox"/></p> <p>4. Renal Arteries <input type="checkbox"/></p> <p style="text-align: center;">Both Rt Lt</p> <p>5. Iliac Arteries <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Leg Arteries <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Graft Surveillance <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> Single Visit Only <input type="checkbox"/> Multiple</p> <p style="padding-left: 20px;">Review <input type="checkbox"/> 6 wk <input type="checkbox"/> 3 mth <input type="checkbox"/> 6 mth <input type="checkbox"/> 1 yr</p> <p>8. Leg Veins <input type="checkbox"/> ?DVT <input type="checkbox"/> Follow-up DVT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Leg Veins - CVI - Incompetence Study <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Leg Vein Harvest (Mapping) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Arm Arteries <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Both Rt Lt</p> <p>12. Radial Arteries (Pre-CABGS) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Arm Veins <input type="checkbox"/> ?DVT <input type="checkbox"/> Follow-up DVT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Arm Vein Harvest (Mapping) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Arteriovenous fistula (AVF) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Renal Transplant <input type="checkbox"/></p> <p>17. Ovarian Veins <input type="checkbox"/></p> <p>18. Internal Mammary Artery Mapping <input type="checkbox"/></p> <p>OTHER</p> <p>19. Resting Ankle/Brachial Indices (ABI) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Exercise Ankle/Brachial Indices (ABI) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>21. Other..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>		

Clinical Notes	Location
	<p>Dandenong Hospital Melway Map Reference 90 E4 Street parking available at David and Cleeland Streets</p>