Monash Health Imaging

Vascular Ultrasound Service

Monash Health Imaging
Level 2 - Monash Medical Centre Clayton
246 Clayton Road, Clayton Victoria 3168
Telephone: 9594 2200 *Email:* dicentral@monashhealth.org

Patient Details	Referring Doctor
UR:	Name: .....
Name:	Baret role: .....
Sex: Male / Female	Inpatient unit: ..... JMS of outpatient unit: .....
DOB: ..... /...../	Mobile: .....
Telephone:	Provider Number: .....
Mobile:	Address: .....
Address:	.....
.....	Signature: .....
.....	Date ..... /...../ .....

Report Destination (please circle)

Routine: ..... Telephone: .....

Fax to: ..... Email to: .....

Investigation Requested

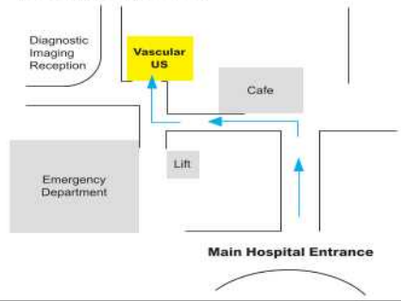
	Both	Right	Left
HEAD/NECK			
1. Carotid	☐		
2. Temporal Arteries (GCA)	☐		
3. Neck Veins	☐		
BODY	☐		
4. Aorta and Iliac Arteries (only)	☐	☐	☐
5. AAA / Post EVAR	☐		
6. AAA / Post FEVAR	☐		
7. Post EVAR w Contrast (CEUS)	☐		
8. Iliac Arteries / Veins (Pre Renal Tx.)	☐		
9. Mesenteric / Splenic Arteries	☐		
10. Renal Arteries	☐	☐	☐
11. Renal Transplant	☐		
12. Ovarian / Gonadal Veins	☐		
LOWER LIMB			
13. Lower Limb Arteries (Inc. Ao/Iliacs)	☐	☐	☐
14. Lower Limb Arteries	☐	☐	☐
15. Lower Limb Veins (DVT/SVT)	☐	☐	☐
16. Lower Limb Veins (CVI)	☐	☐	☐
17. Lower Limb Vein Mapping	☐	☐	☐
UPPER LIMB			
18. Haemodialysis Fistula (AVF)	☐	☐	☐
19. Upper Limb Veins (DVT/SVT)	☐	☐	☐
20. Upper Limb Vein Mapping	☐	☐	☐
21. Upper Limb Arteries	☐	☐	☐
22. Radial Arteries (Pre CABG)	☐	☐	☐
23. Thoracic Outlet Assessment (TOS)	☐	☐	☐
PHYSIOLOGICAL TESTING			
24. Ankle Brachial Indices (Resting only)	☐	☐	☐
25. Ankle Brachial Indices (Exercise)	☐	☐	☐
26. Finger Pressures	☐	☐	☐
27. Penile Doppler (with injection)	☐		

OTHER .....

Clinical Notes

Location

Monash Medical Centre, Clayton, Level 2,
Monash Health Imaging
Vascular Ultrasound



RIS LABELS *RIS LABELS* *RIS LABELS*

Diagnostic Imaging Use Only

MIT / NMT / Sono 3C

Correct Patient
(Patient to state, Full name, DOB, Address) where practical
Please tick 3 relevant Patient Identifiers before commencing examination
Full name ☐ DOB ☐ Address ☐ Wristband ☐ Ankleband ☐
Ward / ED staff / Relative assisted with identity of patient ☐

Pregnancy Check
N/A ☐
Patient states "NOT" pregnant? Confirmed ☐
bHCG Value:(if applicable) .....

Correct Procedure Yes ☐ No ☐ (Patient verification with clinical history as required)

Correct Side/Site Yes ☐ No ☐ N/A ☐ **MIT / NMT /Sono (Signature):** .....

Intervention Team

Time Out (Interventional studies only, checklist completed by scout nurse)
NB: Performed immediately prior to commencement of intervention.

1. Correct patient verified? Yes ☐ Safe to proceed, step (2)
2. Procedure matches consent? Yes ☐ Safe to proceed, step (3)
3. Correct side/site identified and marked with indelible pen? Yes ☐ N/A ☐ Safe to proceed, step (4)
4. L/R orientation confirmed on in-room monitor/image acquisition system Yes ☐ N/A ☐ Safe to proceed
   MIT (initial) .....

Date: ..... *Time:* .....
Proceduralist / fellow / registrar: (PRINT name): ..... Nurse/MIT/Sono: .....
Signed Proceduralist / fellow / registrar .....

Radiologist

Examination Details
Protocol:

Code: ..... Dr Initials: .....
Machine preference, ...
I.V. Contrast required Yes ☐ No ☐
Oral Contrast required Yes ☐ No ☐
Recall details / sequences as required: .....

Clerical

Films to be printed ☐ Comments: .....
CD to be burnt ☐ .....
Patient to take ☐ .....

MIT / NMT / Sono

RIS Procedure details
Radiation Dose / Fluoroscopy time:
Radiologist / NM Physician:
MIT/NMT:

Contrast Medium & Batch No:
Type / Volume:
Contrast Reaction? Yes ☐ No ☐
Time when oral contrast given:

Examination comments (free text)
(no disparaging or inappropriate comments about the patient allowed here)

☐ Patient uncooperative-movement
☐ No images obtained
☐ Some images obtained
☐ Pt Claustrophobic
☐ Pt rebooked for sedation
☐ Pt refused sedation