HMC VASCULAR DIAGNOSTIC SERVICE Box 359971 206-744-8048 206-744-8653 FAX

Request from Specialty/Service ***REQUIRED***	Nursing Unit ***REQUIRED***
Attending Physician ***REQUIRED***	Attending Physician UPIN ***REQUIRED***
Resident Physician ***REQUIRED***	Resident Physician Beeper ***REQUIRED***

EXAMINATION REQUESTED: ***(Check all that apply)***

CEREBROVASCULAR
- ☐ Carotid / Vertebral Duplex

PERIPHERAL ARTERIAL
- ☐ Ankle/Arm Pressure Indices
- ☐ Toe/Brachial Pressure Indices
- ☐ Exercise Treadmill Test (for claudication)
- ☐ Lower Extremity Arterial Duplex
  (Can pt. tolerate treadmill eval. ☐ Y or ☐ N)
- ☐ Lower Extremity Arterial Bypass Duplex
- ☐ Upper Extremity Arterial Duplex
- ☐ Upper Extremity Arterial Bypass Duplex
- ☐ Digit Photoplethysmography Evaluation
- ☐ tcPo2 Evaluation

VISCERAL VASCULAR *(*Fasting Requirement, NPO after midnight)*
- ☐ Renal Artery Duplex*****
- ☐ Mesenteric Artery Duplex*****
- ☐ Portal / Splenic Vein Duplex*****
- ☐ Aorta/Iliac Artery Duplex* **(R/O Stenosis or AAA)**
- ☐ Post EVAR Duplex*
  Date of EVAR_____Device_____
- ☐ Abdominal Bypass Graft Duplex*
  Date of Bypass_____ Graft Type_____

Please state patient symptoms in brief clinical history below.

LOWER EXTREMITY VENOUS
- ☐ Lower extremity duplex **(R/O DVT)**
- ☐ Reflux Study **(Evaluate for incompetent valves)**
- ☐ LE Vein Mapping **(pre-bypass or harvest)**

Please state patient symptoms in brief clinical history below.

UPPER EXTREMITY VENOUS
- ☐ Upper Extremity Venous Duplex **(R/O DVT)**
- ☐ **Rt. or ☐ Lt.**
- ☐ UE Vein Mapping **(pre-bypass, pre-dialysis access)**

MISCELLANEOUS
- ☐ Thoracic Outlet Syndrome Testing
- ☐ Cold Sensitivity Evaluation
- ☐ Dialysis Access Duplex

Please state patient symptoms in brief clinical history below.

OTHER EXAMINATION:
- ☐ _____

CLINICAL INDICATIONS:

☐ UE Pain	☐ Known Atherosclerosis
☐ UE Swelling	☐ Graft
☐ CVA	☐ Known Aneurysm
☐ TIA	☐ Injury to vessel
☐ Bruit	☐ Discoloration
☐ Hypertension	☐ Cold, pulseless limb
☐ LE Pain/Swelling	☐ Other_____

BRIEF CLINICAL HISTORY:
(Required)

PHYSICIAN/PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME

PT.NO

NAME

Place EPIC Label Within Box

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

VASCULAR EXAM NON-INVASIVE PRCD ORD

WHITE – MEDICAL RECORD