HAMILTON VASCULAR LAB

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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
- ❒ Venous mapping

❒ **CLINICAL CONSULTATION**

❒ **AV DIALYSIS GRAFT EXAM**

❒ **OTHER** _____

Clinical Information _____

_____

Referring Doctor _____ Billing # _____

Appointment Time _____

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