

Name:

MRN: DOB:		Located within the Surgery Outpatient Clinic at the ACC Main Pavilion, Level 5	
		111 Colchester Avenue Burlington, VT 05401	
Reason for Exam:		Phone: (802)847-4548 Fax: (802)847-3581	
Patient Special	Needs:	(
Does this patier	nt need a consult with a vascular surgeon o	on the same day? YES NO	
	Vascular Exami	ination Request Form	
	Cerebrovascular Exams	Upper Extremity Arterial Exams	
☐ Carotid/Ver Bilate	rtebral Imaging ral Right Left	□ Pulse Volume Recordings & Segmental Pressures	
	al Doppler Imaging	□ Arterial Imaging Bilateral Right Left	
Lov	ver Extremity Arterial Exams	☐ Hemodialysis Access Fistula Imaging	
	ne Recordings & Segmental Pressures	□ Other/Specify Site:	
□ PVRs & Seg □ Arterial Ima Bilate		Venous Exams	
□ Other/Speci	<u> </u>	☐ Venous Thrombosis (DVT/SVT) Imaging Bilateral Right Left Leg(s) Arm(s)	
(Fastir	Abdominal Exams ng after midnight, take medications.)	□ Venous Insufficiency (varicose veins) Bilateral Right Left	
	Aorta/Iliac Imaging (AAA)	☐ Preoperative Vein Map Bilateral Right Left Leg(s) Arm(s)	
 □ Renal Artery Imaging □ Mesenteric Artery Imaging □ Portal Vein Imaging □ Other/Specify Site: ————————————————————————————————————		□ Pending Surgical Procedure:	
		□ Other/Specify Site: -	
Date:	Pager:	Referring (Print Name):	
Contact Person/N	Number: Signatu	re:	

Vascular Diagnostic Laboratory