VASCULAR ULTRASOUND REQUEST FORM

Radiology Department, Direct Line: (020) 7460 5746 / 5747
Radiology Department, Direct Fax: (020) 7835 2496 / (020) 7460 5576

Bupa CROMWELL HOSPITAL

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
All sections of this form must be fully completed

Monday:	2.00 – 7.30
Tuesday:	3.00 – 5.30
Wednesday:	2.00 – 4.30
Thursday:	9.00 – 11.30
Friday:	9.00 – 11.30

Patient Details: Place Sticker Here

Name: _____

Date of birth: _____

Hospital No: _____ Sex: M F

Appointment

Date: _____ Time: _____

Referring Consultant / GP: _____

Report / CD to: _____

PLEASE GIVE THIS FORM TO OUTPATIENTS BEFORE GOING TO VASCULAR LAB

SPECIAL INSTRUCTIONS:

Allergies: _____

HEP B Status _____

MRSA Status _____

Chg. No.	Tick	Exam		
638010		Ankle Pressure		
638008		Aortic Duplex ***STARVE		
638025		Aneurysm Duplex ***STARVE		
638026		AV Fistula / Access Duplex	R	L
638004		Cartoid Duplex Scan		
638009		Exercise Pressure Test		
638011		False Aneurysm	R	L
638007		Graft Surveillance ***STARVE	R	L
638003		Lower Limb Arterial Duplex Bilateral ***STARVE		
638032		Lower Limb Arterial Duplex Unilateral ***STARVE	R	L
638035		Lower Limb Venous Duplex unilateral	R	L
638002		Lower Limb Venous Duplex bilateral		
638001		Pre-Op Vein Marking	R	L
638006		Upper Limb Arterial Duplex	R	L
638005		Upper Limb Venous Duplex	R	L
639015		Guidance Venous Ablation Unilateral	R	L
639016		Guidance Venous Ablation Bilateral		
638012		EMERGENCY CALL OUT x 1		
638020		EMERGENCY CALL OUT x 2		

CLINICAL HISTORY & reason for Exam:

(Past medical or surgical information)

Referring Clinician Signature

Signature: _____

Date: _____

***STARVE:** Nothing to eat or drink 4 hours prior to exam, medications can be taken with small amount of still water

Operator: _____

Date: _____