VASCULAR ULTRASOUND LAB REQUISITION

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Fax: 613-548-2413
KGH Site
Tel: 613-549-6666 Ext: 3050

CR#: _____ Sex: Female ☐ Male ☐

Name *(Last, First):* _____

Health Card # _____

Date of Birth: _____ Age: _____

Address: _____

Phone: *(Home)* _____ *(Work)* _____

INPATIENT ☐	**ER/UCC** ☐	**OUTPATIENT** ☐
Service:		
Floor/Section:	Room #:	

Patient in Isolation: NO ☐ YES ☐ (Specify type:_____)

Patient Transport: Walking ☐ Wheelchair ☐ Stretcher ☐ Bed ☐ O2 ☐

EXAMINATION REQUESTED

VASC US CAROTID
- □ Carotid arteries (includes vertebral arteries)
- □ Subclavian arteries

VASC US EXTREMITY
- □ Arterial Arms □ L □ R
- □ Arterial Legs □ ABIs
- □ Pseudoaneurysm (specify site): □ Stent/graft/bypass follow-up

VASC US EXTREMITY
- □ Venous Arms □ L □ R
- □ Venous Legs □ Stent follow-up

VASC US ABDOMENAL/PELVIS
- □ AAA Screening/Follow-up
- □ Post EVAR Follow-up

VASC US EXTREMITY
- □ Dialysis Graft/Fistula □ Venous mapping (pre-fistula)

□ Other(specify):

_____

Additional Information:

_____

_____

Prior Imaging:

INDICATION/HISTORY

- □ Claudication
- □ Tiredness/Numbness
- □ Ischemic Rest Pain
- □ Ulceration/ tissue loss
- □ Varicose veins
- □ Venous stasis/ulcers
- □ R/O DVT
- □ Prior DVT Follow-up
- □ Venous insufficiency
- □ Swelling
- □ Dizziness/Vertigo
- □ Amaurosis Fugax
- □ Subclavian steal
- □ Asymmetric BP
- □ Other (specify):

_____

_____

Ordering Provider Signature: _____

Name: (Last, First)_____
(printed name)

CPSO:_____

Ordering Provider phone/pager# :_____

Attending Physician:_____

Copy Report to:_____
(please print full name)

Date requisition complete:_____
YYYY/MM/DD

Patient Information:

- Test take approximately 60 minutes, please arrive 15 mins prior to your appointment
- Do not smoke/vape/chew gum prior to your test
- Bring your health card
- Directions: Take the main elevators to the 7th floor. Follow signs to the Vascular Lab