Date: _____

Lower Extremity Arterial Doppler Worksheet

Patient Name: _____

MRN #: _____

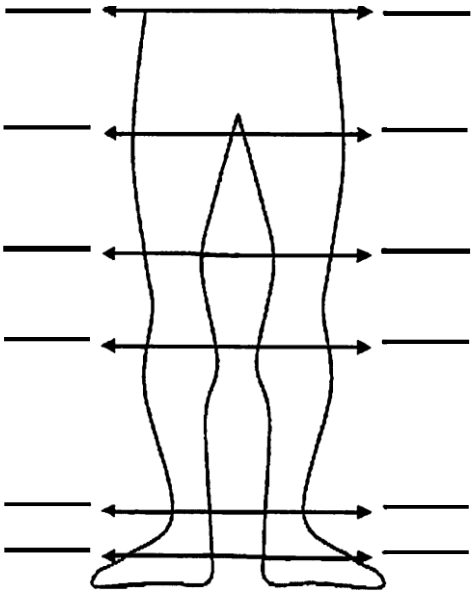
Age: _____ **Sex:** _____ **Referring Physician:** _____

History:

- ☐ Claudication
- ☐ Limb Pain at Rest
- ☐ Ulcer
- ☐ Gangrene/Cyanosis
- ☐ Absent Pulse(s)
- ☐ Arterial Trauma / Rupture
- ☐ Aneurysm / Pseudoaneurysm
- ☐ Vascular Graft Complications
- ☐ Follow-up Vascular Surgery
- ☐ Follow-up Angioplasty
- ☐ AV Fistula
- ☐ Embolism or Thrombosis
- ☐ Other _____

	Right			Left		
	Multi	Mono	Absent	Multi	Mono	Absent
Common Femoral						
Femoral						
Popliteal						
Posterial Tibial						
Dorsal Pedis						

Brachial Arterial Pressures



Right ABI	Left ABI

Comments:

Technologist: **Radiologist:**

SYNERGY RADIOLOGY ASSOCIATES