Lower Extremity Venous Doppler Worksheet

Patient Name: _____

MRN #: _____

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

History: **(Indicate R, L or B in all blanks that apply)**

_____ Leg Pain

_____ Leg Swelling

_____ Pulmonary Embolism / Infarction

_____ Unexplained Respiratory Symptons

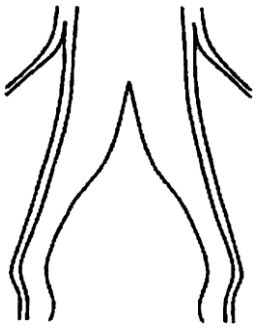
_____ Stasis Ulcers

_____ Gangrene

_____ Varicose Veins

_____ Venous Insufficiency

_____ Other _____



	Right				Left			
	Spontaneous	Phasic	Comp	Aug	Spontaneous	Phasic	Comp	Aug
Common Femoral								
Femoral								
Popliteal								
Posterior Tibial								
Greater Saphenous								

Comments:

Technologist: Date: Time:

SYNERGY RADIOLOGY ASSOCIATES