Upper Extremity Venous Doppler Worksheet

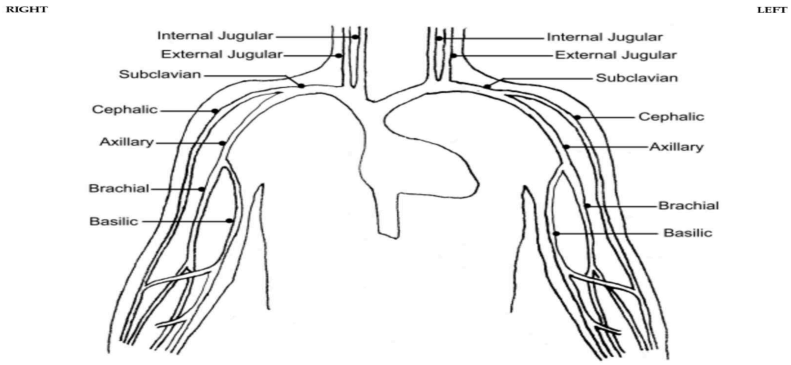
Patient Name: _____

MRN #: _____

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

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

_____ Arm Pain	_____ History of Thoracic Malignancy
_____ Arm Swelling	_____ Venous Thrombosis
_____ Facial Swelling	_____ Follow-Up Examination
_____ Central Venous Line	_____ Other _____



Deep Veins	Right				Left			
	Spontaneous	Plastic	Comp	Aug	Spontaneous	Plastic	Comp	Aug
Jugular								
Subclavian								
Axillary								
Brachial								
Basilic								
Cephalic								
Radial								
Ulnar								

Comments: _____

Technologist: Date: Time:

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