



KITCHENER-WATERLOO VASCULAR LABORATORY



*Accredited Vascular
Laboratory*

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NAME _____ PT. TEL: _____

OHIP No: _____ D. O. B. _____

PERIPHERAL ARTERIAL

- ☐ Carotids
- ☐ Aorta & iliac (Aneurysm Screening)
- ☐ Lower extremities bilateral
(Incl. Aorta, iliacs, ABI, TBI)
- ☐ Upper extremities bilateral
- ☐ ^{R L} Lower extremity unilateral
- ☐ ^{R L} Upper extremity unilateral

PERIPHERAL VENOUS

- ☐ Lower extremities bilateral
(with IVC & iliacs)
- ☐ Upper extremities bilateral
- ☐ ^{R L} Lower extremity unilateral
- ☐ ^{R L} Upper extremity unilateral

Other: _____

☐ **CLINICAL CONSULTATION REQUEST IF ABNORMAL**
(Attach Patient Profile and Clinical History)

Clinical Information _____

Appointment time: _____

Referring Doctor: _____ Billing #: _____

Clinic: _____ Ph: _____ Fax: _____