COMPU-SOUND

VASCULAR ULTRASOUND CLINIC

3000 LAWRENCE AVENUE EAST, BUILDING B, SUITE 2203
SCARBOROUGH, ON M1P 2V1

416-431-5885

FAX: 416-431-1272

NAME _____

PHONE _____

APP'T. DATE _____ TIME _____

REASON FOR EXAM ☐ See Over

_____

_____

_____

EXAM REQUIRED:

- ❑ **CAROTID DUPLEX**
- ❑ **ECHO CARDIOGRAPHY (2D & Colour Doppler)**

ARTERIAL:

- ❑ **Lower Extremities (Incl. Aorta)**
- ❑ **Upper Extremities**

VENOUS: (Imaging for DVT)

- ❑ **Lower Extremities (incl. Iliac veins, IVC):**
- ❑ **Upper Extremities**

- ❑ **ABDOMINAL AORTA**
- ❑ **THORACIC OUTLET SYNDROME**
- ❑ **RAYNAUD'S EVALUATION / Cold Hand Study**
- ❑ **VISCERAL BRANCHES (Celiac, SMA, IMA)**
- ❑ **RENAL ARTERIES (incl. Aorta)**
- ❑ **OTHER** _____

Dr. _____ **per** _____

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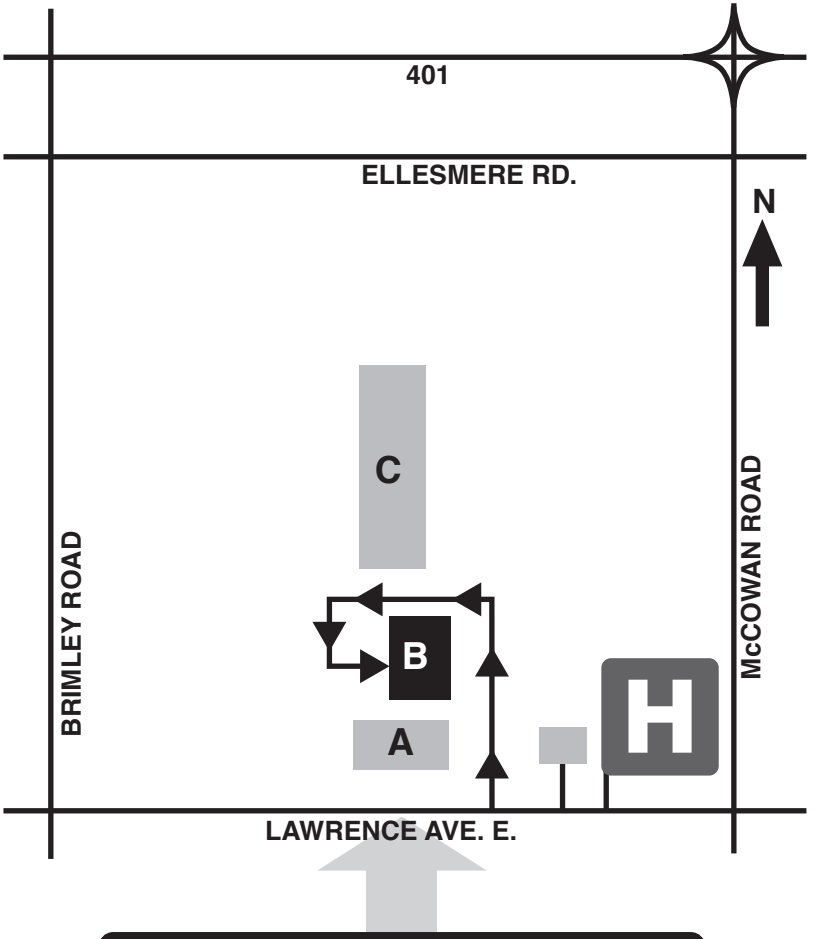

3000 Lawrence Avenue East
Building B, Suite 2203
Use Rear Entrance

ONE HOUR FREE PARKING

BRING PARKING TICKET TO OFFICE TO BE STAMPED