

COMPU-SOUND

VASCULAR ULTRASOUND CLINIC

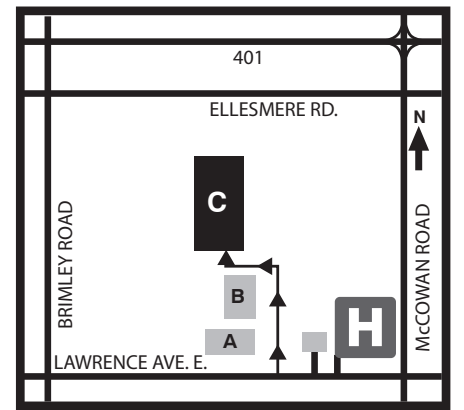
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 BUILDING C, SUITE C02
 SCARBOROUGH, ON. M1P 2V1

TEL: 416-431-5885

FAX: 416-431-1272

www.compusoundvascular.ca

Mon-Thurs:
 - 8:00am to 4:00pm
 Fri:
 - 8:00am to 3:30pm
 Evenings:
 - By Appointment



FIRST HOUR FREE PARKING
 BRING PARKING TICKET TO OFFICE TO BE STAMPED

NAME _____

REASON FOR EXAM (or Check Box Below)

PHONE _____

APPT. DATE _____ TIME _____

URGENT BOOKING: VERBAL:

Dr. _____ Per _____

ARTERIAL DUPLEX EXAM:

(Lower Arterial incl: AAA exam and Segmental Pressure Evaluation-ABI/TBI)

Lower Extremities:

- Indications: Rule Out PVD/Follow up PVD Claudication
 Graft Surveillance Ischemic Ulcers
 Absent or Diminished Pulses

Upper Extremities

- Cold Sensitivity (Raynaud's)
 Thoracic Outlet Syndrome
 Brachial B.P. Differential

VENOUS DUPLEX EXAM:

Lower Extremities Upper Extremities

- Indications: Rule out DVT Follow up DVT Fistula/Graft Surveillance
 Swelling/Pain Venous Insufficiency Left Right
 SVT Varicose Veins Ulcer Pre-Op Mapping
 Fistula Creation Other

AORTIC SCREENING FOR ANEURYSM:

- Indications: Rule out Aneurysm Graft Surveillance Risk factors:
 Follow up Aneurysm EVAR Over 65 Smoking
 Hypertension

CAROTID DUPLEX EXAM:

RENAL ARTERY DUPLEX EXAM:

- Indications: TIA Stroke Dizziness Bruit High Blood Pressure Elevated Creatinine
 Risk Factors Amaurosis Aneurysm Renal Artery Disease

ECHOCARDIOGRAPHY (2D & COLOUR DOPPLER):

- Chest Pain Shortness of Breath Palpitations Abnormal ECG Dizziness/Syncope
 Other _____

HOLTER MONITORING: 48HRS. 72 HRS. 14 Days 28 Days

OTHER STUDY: _____

ALL STUDIES PERFORMED ONLY BY REGISTERED VASCULAR AND CARDIAC TECHNOLOGISTS

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: <http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx>