

Melbourne ascular Diagnostics

At Epworth Centre Suite 2, 7th Floor, 32 Erin Street, Richmond 3121
Ph: 9428 8044 Fax: 9428 0644

Surname _____
Given Name _____ DOB _____
Address _____

Ref Dr _____
Provider No. _____
Ph: _____ Fax: _____
Email: _____
Address _____

Clinical Notes

Signed _____ Date _____

Test Required (Please circle)

- | | |
|-----------------------------|-----------------|
| 1. Doppler Pressure Studies | Rest / Exercise |
| 2. Toe Pressure Study | |

Colour Duplex Scans

- | | |
|---|------------------------------------|
| 3 Carotids | <input type="checkbox"/> Right |
| 4 Graft Surveillance | <input type="checkbox"/> Left |
| 5 Lower Limb Arterial | <input type="checkbox"/> Bilateral |
| 6 Aortoiliac Arteries | |
| 7 Lower Limb DVT | |
| 8 Venous Insufficiency (Varicose Veins) | |
| 9 Vein Mapping (For Harvest) | |
| 10 Compartment Syndrome | |
| 11 Mesenteric Arteries (8 hour fast) | |
| 12 Renal Arteries (4 hour fast) | |
| 13 AAA | |
| 14 Arm Arterial (for CABG inc Allens test) | |
| 15 Intraoperative (please specify in notes) | |
| 16 Thoracic Outlet Syndrome | |

APPOINTMENT Please attend the Melbourne Vascular Diagnostics Laboratory on _____ at _____

Mr William Campbell F.R.A.C.S (Vasc.)