REQUEST FOR VASCULAR ULTRASOUND

Department of Radiology The London Clinic

For APPTS: 020 7616 7653
FAX: 020 7616 7679

Patient's Surname: First Name:	Male / Female Date of Birth: Hosp Number:

Patient's Address: Phone Number:	Outpatient Inpatient / DC – Room No: Walking / bed / trolley / wheelchair / drips etc High Risk Case – YES / NO Barrier / Reverse Barrier Nursing – YES / NO

Invoice To – Patient / Doctor
(Policy and authorisation details MUST be supplied if invoice is to be sent to insurer)

Referring Doctor: Send report to:

Telephone Number:

Code	✓	Examination Required	Please indicate		
DIVLLD		**Venous Lower Limb Duplex**	**R**	**L**	**B**
DIVLLA1		**Unilateral Arterial Lower Limb Duplex (Fasting)**	**R**	**L**	
DIVLLA2		**Bilateral Arterial Lower Limb Duplex (Fasting)**			
DIVVM		**Venous Pre- OP Marking**	**R**	**L**	**B**
DIVAD		**Aortic Duplex (Fasting)**			
DIVPA		**Popliteal Aneurysm**	**R**	**L**	**B**
DIVCD		**Carotid & Vertebral Duplex**			
DIVEXER		**Exercise Test – Pre / Post ABPI**			
DIVFAN		**False Aneurysm**	**R**	**L**	**B**
DIVAGS		**Graft Surveillance Lower Limb (Fasting)**	**R**	**L**	**B**
DIVULA		**Upper Limb Arterial Duplex**	**R**	**L**	**B**
DIVULV		**Upper Limb / Central Venous Duplex**	**R**	**L**	**B**
DIVAP		**Ankle Pressures (ABPI)**			
DIVACU		**Aorta / Carotid Duplex Health Screen (Fasting)**			
DIVULPFA		**Upper Limb Pre Fistula Access / Fistula**	**R**	**L**	**B**
DIVVE		**Medico Legal Charge**			
		On Call Charge 1 Test			
		On Call Charge 2 Tests			

Clinical Details – Please include any history of previous intervention, relevant symptoms etc

Appointment ....
Time ....

Previous investigation at The London Clinic - YES / NO

Clinician's signature: Date:

Harlow Healthcare Tel: 0191 455 4286 45276dtp

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