IMAGEN

UPPER EXTREMITY ARTERIAL DOPPLER EVALUATION

Date: Patient Name:

Patient ID#: Accn#: Ordering Provider:

Order Status:

☐ Regular Reason for Exam (Symptoms/Indication): Choose or Type

☐ STAT

Past Relevant Surgical History:

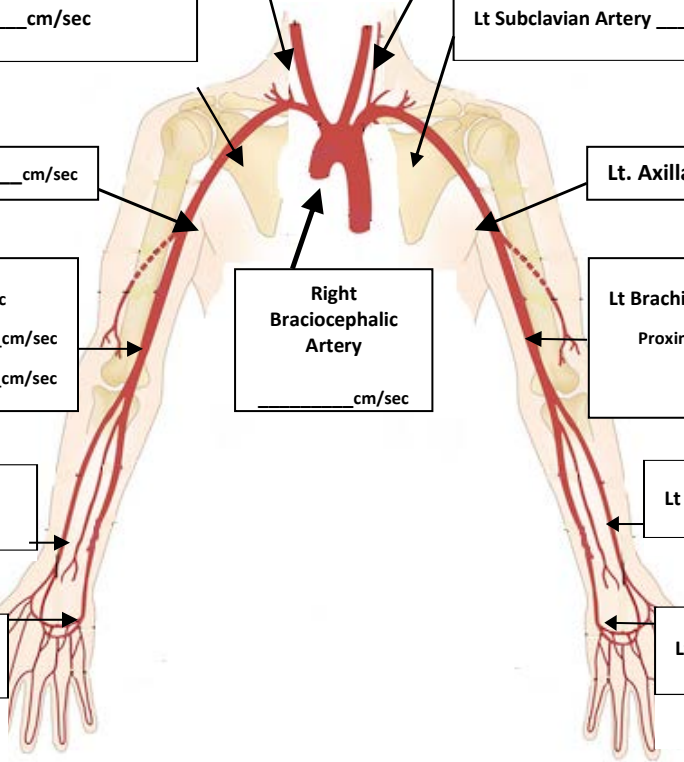
Past Relevant Medical History:

Previous Exams & Dates:

Extremity Examined: ☐ Right ☐ Left ☐ Both

Findings:

RIGHT	LEFT
Rt Common Carotid Artery _____cm/sec	Lt Common Carotid Artery _____cm/sec
Rt Subclavian Artery _____cm/sec	Lt Subclavian Artery _____cm/sec
Rt Axillary Artery _____cm/sec	Lt. Axillary Artery _____cm/sec
Rt Brachial Artery _____cm/sec Proximal Rt. Brachial_____cm/sec Distal Rt. Brachial_____cm/sec	Lt Brachial Artery _____cm/sec Proximal Lt. Brachial_____cm/sec Distal Lt. Brachial_____cm/sec
Rt Radial Artery _____cm/sec	Lt Radial Artery _____cm/sec
Rt Ulnar Artery _____cm/sec	Lt Ulnar Artery _____cm/sec



Right Braciocephalic Artery _____cm/sec

Additional Comments:

Sonographer Name: Contact Phone Number: