



SADDLEBACK VASCULAR LABRATORY

Patient Name _____

Patient Phone _____

Referring Physician _____

Referring Physician Signature _____

Add. Copies to _____

Date of Exam _____ Time _____

Indications/Diagnosis _____

Examination Requested _____

[N.I.C.E.] Carotid Duplex Ultrasound _____

Lower Extremity Arterial Evalutaion _____

Other Arterial Evalutaion _____

Varicose Ultrasound Evaluation _____

Acute DVT suspected (will be performed same day of request.) _____

Abdominal Vascular Ultrasound _____

Other _____

Special Instructions _____

Patient Test Instructions On Back Side