OSHAWA DIAGNOSTIC & VASCULAR IMAGING

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NAME _____ DATE _____

PHONE _____ D. O. B. _____

REQUEST FOR ASSESSMENT

VASCULAR

- ☐ Vascular Consultation
  (include pertinent patient information)
- ☐ Carotid Doppler
- ☐ Aorta (for Aneurysm)
- ☐ Lower Arteries
- ☐ Lower Veins ☐ R ☐ L
- ☐ ABI's
- ☐ AV Mapping for Dialysis
- ☐ Fistula ☐ R ☐ L
- ☐ Upper Arteries
- ☐ Upper Veins ☐ R ☐ L
- ☐ Temporal Arteries
- ☐ Renal Artery Study

CARDIAC

- ☐ Cardiology Consultation
- ☐ Stress Test
- ☐ Echocardiography
- ☐ Holter Monitoring
  - ☐ 48 Hrs. ☐ 72 Hrs.
- ☐ Other _____
  _____

Appointment:
Date _____
Time _____

Clinical Information _____

_____

_____

Referring Doctor _____ MD