MAYFAIR® DIAGNOSTICS

VASCULAR ULTRASOUND

A booking coordinator will contact patients to schedule appointments once the requisition has been triaged.

All requisitions must be faxed to 403.777.3001

PATIENT INFORMATION

PLACE PATIENT LABEL HERE

Date of Request: D/ M/ Y/

Name: ☐ Female ☐ Male

Address:

City: Province: Postal Code:

Home Phone:

Other Phone:

Date of Birth: D/ M/ Y/

AHC or WCB #:

Physician's Name:

Prac. ID #:

PROFESSIONAL SERVICES

Head and Neck

- ☐ Carotid Doppler Incl. Vert/SCA
  - ☐ Include IMT
- ☐ Temporal Arteries
- ☐ Thoracic Outlet Syndrome

Abdominal Assessment

- ☐ Liver Transplant Doppler
- ☐ Mesenteric Vessels
- ☐ Renal Artery Doppler
- ☐ Renal Transplant

Venous Assessment

- ☐ Venous (DVT) ☐ R ☐ L ☐ Arm ☐ Leg
- ☐ Venous Insufficiency (referral from vein specialist/ vascular surgeon required)
  - ☐ R ☐ L ☐ Bilateral

Peripheral Arterial Assessment

- ☐ ABI +/- TBI Only
- ☐ Aorta and Iliac Assessment
- ☐ Duplex Lower Extremity w/ ABI +/- TBI ☐ R ☐ L
  - ☐ Dedicated Tibial Arterial Assessment
- ☐ Duplex Upper Extremity ☐ R ☐ L
- ☐ LE Segmental Pressures w/TBI ☐ R ☐ L
- ☐ Popliteal Artery Entrapment Syndrome
- ☐ Raynauds Assessment ☐ UE ☐ LE

Graft/Stents

- ☐ Bypass Graft
- ☐ Endovascular Graft/Stent PTA
- ☐ EVAR Surveillance
- ☐ Hemodialysis Fistula/Graft

Indicate site of the above:

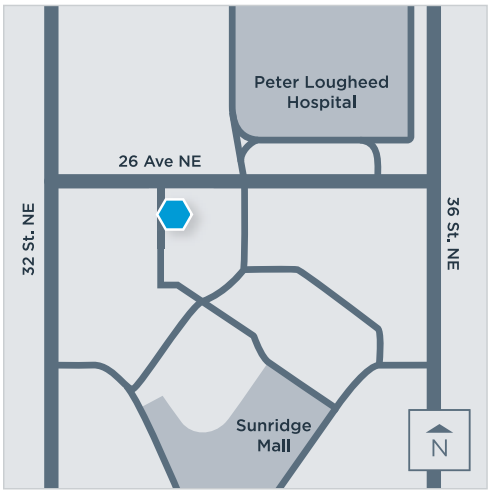
Other

Specify area to be assessed:

HISTORY

Please complete this section with as many details as possible, this enables our clinic staff to provide the most comprehensive patient care.

APPOINTMENT DATE AND LOCATION



MAYFAIR® DIAGNOSTICS

Sunridge Plaza
150, 3363 – 26th Avenue NE
Monday to Friday
8 a.m. – 4 p.m.

For more requisition forms please email bd@radiology.ca.

VASCULAR SURGEON APPOINTMENT DATE:

URGENT: ☐ **Within 48 hours**

☐ **Within one week pre-angio**

OTHER SPECIALIST APPOINTMENT DATE: