



Doctors Office Center Vascular Laboratory

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Frank T. Padberg, MD
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PATIENT: _____ **DATE:** _____

Indications (required): _____

STUDY REQUESTED

VENOUS DUPLEX

- | | | | |
|-----------------|--------------------------------|-------------------------------|-------------------------------|
| Upper extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| Lower extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

ABI ONLY

SEGMENTAL PRESSURES (PVR)

- | | | | |
|-----------------|--------------------------------|-------------------------------|-------------------------------|
| Upper extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| Lower extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

ARTERIAL DUPLEX

- | | | | |
|-----------------|--------------------------------|-------------------------------|-------------------------------|
| Upper extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| Lower extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

Graft type (if any): _____

CAROTID DUPLEX (BILATERAL)

DIALYSIS ACCESS SCAN Specify side/type: _____

VEIN MAPPING Upper (for HD) Lower (for CABG/bypass)

REFLUX (VARICOSE VEIN) TESTING

AORTO-ILIAC DUPLEX **MESENTERIC DUPLEX**

OTHER: _____

Prescriber Name: _____

Prescriber Signature: _____

Phone: _____ **Fax:** _____

NPI: _____ **Auth#:** _____