

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_**

**Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tech: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Lower Extremity**

**Venous Ultrasound**

Bilateral [ ]  Unilateral: RT [ ]  LT [ ]

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**RIGHT LEG Yes No**

**CFV:**

Flow:Compression:

**GSV:**

Flow:Compression:

**SFV P:**

Flow:Compression:

**SFV M:**

Flow:Compression:

**SFV D:**

Flow:Compression:

**Pop V:**

Flow:Compression: Baker’s Cyst:

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Flow:Compression:

**NO RT DVT: ☐**

**LEFT LEG Yes No**

**CFV:**

Flow:Compression:

**GSV:**

Flow:Compression:

**SFV P:**

Flow:Compression:

**SFV M:**

Flow:Compression:

**SFV D:**

Flow:Compression:

**Pop V:**

Flow:Compression: Baker’s Cyst:

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Flow:Compression:

**NO LT DVT: ☐**