Upper Extremity Venous Ultrasound

Patient Name: _____ **MR#:** _____ **Date:** _____/_____/_____

Referring Physician: _____ **Tech:** _____

Reason for Study: _____

Patient History: _____

_____

— RIGHT UPPER EXTREMITY —

	Yes	No
Internal jugular:		
Flow:	☐	☐
Compression:	☐	☐
Subclavian:		
Flow:	☐	☐
Axillary:		
Flow:	☐	☐
Compression:	☐	☐
Cephalic:		
Flow:	☐	☐
Compression:	☐	☐
Brachial:		
Flow:	☐	☐
Compression:	☐	☐
Basilic:		
Flow:	☐	☐
Compression:	☐	☐
Ulnar:		
Flow:	☐	☐
Compression:	☐	☐
Radial:		
Flow:	☐	☐
Compression:	☐	☐

RUE Thrombus seen?

DVT ☐ SVT ☐

No Thrombus seen at this time ☐

— LEFT UPPER EXTREMITY —

	Yes	No
Internal jugular:		
Flow:	☐	☐
Compression:	☐	☐
Subclavian:		
Flow:	☐	☐
Axillary:		
Flow:	☐	☐
Compression:	☐	☐
Cephalic:		
Flow:	☐	☐
Compression:	☐	☐
Brachial:		
Flow:	☐	☐
Compression:	☐	☐
Basilic:		
Flow:	☐	☐
Compression:	☐	☐
Ulnar:		
Flow:	☐	☐
Compression:	☐	☐
Radial:		
Flow:	☐	☐
Compression:	☐	☐

LUE Thrombus seen?

DVT ☐ SVT ☐

No Thrombus seen at this time ☐

Comments: _____

_____