Lower Extremity Venous Insufficiency Study

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

Referring Physician: _____ **Tech:** _____

Reason for Study: _____

Patient History: _____

_____

— Current Visible State of the Patient's Lower Extremities —

C0: No Visible Signs of Venous Disease ☐ **C1:** Spider and Reticular Veins ☐ **C2:** Varicose Veins ☐ **C3:** Edema ☐

C4: Skin Changes (Brawny, Eczema, and/or Scarring) ☐ **C5:** Healed Ulceration ☐ **C6:** Active Ulceration ☐

DEEP SYSTEM REFLUX:

(Distal Augmentation Performed; Insufficiency in deep veins: >1.0 seconds)

Right: No ☐ Yes ☐ Location and time:_____

_____

Left: No ☐ Yes ☐ Location and time:_____

_____

SUPERFICIAL SYSTEM REFLUX:

(Valsalva/Proximal Augmentation Performed; Insufficiency in superficial veins: >0.5 seconds)

Right: No ☐ Yes ☐ Location/Time/Diameter: _____

_____

Left: No ☐ Yes ☐ Location/Time/Diameter: _____

_____

INCOMPETENT PERFORATORS:

(Valsalva/Proximal Augmentation Performed; Insufficiency in perforators: >0.35 seconds or >3.5 mm)

Right: No ☐ Yes ☐ Location/Time/Diameter: _____

_____

Left: No ☐ Yes ☐ Location/Time/Diameter: _____

_____

Thrombus Seen: **No** ☐ **Yes** ☐ Comments: _____

_____

Right : CFV ☐ SFV Prox ☐ DFV ☐ SFV Mid ☐ SFV Distal ☐ POP V ☐ PTV ☐

GSV @Junction ☐ GSV Upper ☐ GSV Mid ☐ GSV Lower ☐ GSV BK ☐ SSV ☐

Left: CFV ☐ SFV Prox ☐ DFV ☐ SFV Mid ☐ SFV Distal ☐ POP V ☐ PTV ☐

GSV @Junction ☐ GSV Upper ☐ GSV Mid ☐ GSV Lower ☐ GSV BK ☐ SSV ☐

Comments: _____

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