Diagnostic Imaging Vascular Lab

William Osler Health System

Fax: 905-494-6614 ◯ Next available appointment **OR** ◯ Brampton Civic Hospital ◯ Etobicoke General Hospital

Patient Information

Name:_____ Date of Birth*(DD/MM/YYYY)*:_____
Health Card No:_____ Version Code:_____
Address:_____ City:_____ Prov.:_____ Postal Code:_____
Tel:_____ Email:_____

To **request DI exam for discharged ED / UCC patient**, select time frame* for DI exam, and send patient with this requisition to the DI remote / EDDI desk to book DI exam. **Do not fax this requisition.** ◯ Less than 24h ◯ Less than 48h ◯ Less than 10 days ◯ Less than 1 month

Instructions: Do not smoke 1 hour prior to the test.

Examination Requested (***Testing that requires nothing to eat/drink 4 hours prior to test are indicated with*** ***)

1. SCREENING

☐ **AAA (Abdominal Aortic Aneurysm) Screen *****
Recommended once for all men 65 to 75 years.
Recommended once for women 65 years and above with risk factors including: smoking history, family history of aneurysm, cerebrovascular disease

☐ **PAD (Peripheral Arterial Disease) in wound care *****
Recommended in all patients with new or non-healing ulcer greater than 6 week's duration. This will include Duplex study if the toe pressures are less than 55mmHg or ankle pressure is less than 70mmHg

☐ **PAD ABI (Ankle Brachial index)**
Consideration of diagnostic ABI for individuals at risk defined by any one of the following criteria:

- Less than 50 years with diabetes and an additional CVD risk factor
- 50 years and above with a history of smoking or diabetes
- 65 years and above

2. VENOUS

☐ Lower Extremity rule out DVT ☐ Rt ☐ Lt
☐ Upper Extremity rule out DVT ☐ Rt ☐ Lt
☐ Chronic Venous Insufficiency Assessment
☐ Venous mapping ☐ Rt ☐ Lt
☐ ABI for compression stockings

3. ARTERIAL

☐ Leg Arteries *** ☐ Rt ☐ Lt
☐ Arm Arteries ☐ Rt ☐ Lt
☐ Renal Artery Stenosis ***
☐ Post bypass/angioplasty surveillance *** ☐ Rt ☐ Lt

Specify previous vascular surgical procedures
☐ Carotid
☐ Mesenteric Assessment ***
☐ AAA follow-up ***
☐ EVAR (Endovascular Aneurysm Repair) follow-up ***
☐ Thoracic Outlet Assessment
(Includes arterial and venous assessment)
☐ Temporal Doppler (arterial)

4. DIALYSIS ACCESS

☐ Pre-op Dialysis Access Mapping
(arterial and venous)
☐ Fistula Assessment

Specify previous vascular surgical procedures
☐ Renal Transplant Work-Up
☐ Pre ☐ Post

Clinical Questionnaire

Clinical History (Mandatory):

Provider Name (Print): _____ CPSO/OHIP Billing #: _____

Telephone: _____ Fax: _____ Copies to (Provider Name): _____

Provider Signature: _____Date: _____

*Booking date is dependent on appointment availability and radiologist supervised clinical triaging based on provided clinical history
NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING
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