Spectrum Bookings
Ph 02 9197 8100

Spectrum
vascular imaging
www.spectrumradiology.com.au

Vascular Imaging Referral Form

Patient details

Vascular Examination Required

1. Carotid Duplex ☐

2. Peripheral Arterial Study

a. ABI resting & toe pressure ☐
b. ABI & exercise ☐
c. Aorto-iliac Duplex ☐
d. Leg Arterial Duplex L ☐ R ☐
e. Subclavian Brachial Duplex L ☐ R ☐

3. Venous Duplex

a. DVT study L ☐ R ☐
b. Venous Insufficiency L ☐ R ☐
c. Venous Mapping L ☐ R ☐

4. Abdominal Duplex *(FASTING)*

a. Renal ☐
b. Mesenteric ☐
c. Aneurysm ☐
d.IVC and Iliac Venous ☐
e.Ovarian Veins ☐

5. Photoplethysmography

a. Thoracic Outlet L ☐ R ☐
b. Penile Arterial ☐

6. AV Fistula

a. Mapping L ☐ R ☐
b. Progress L ☐ R ☐

Clinical notes

Referring Doctor These sections **MUST** be completed

Name:
Address:
Provider No:
Speciality:
Phone:
Fax:
Signature:
Date:

more referrals needed

*** Please see overleaf for maps and addresses of all our sites**