LOWER E XTREMITY ARTERIAL DOPPLER

Name: _____ Date: _____

Physician: _____ DOB: ____/____/_____ Age: _____

Sonographer: _____

SYMPTOMATIC: R / L ULCERS/GANGRENE: Y / N PULSES: NORMAL / ABNORMAL

Clinical Indications: _____

RIGHT

	TRIPHASIC	BIPHASIC	MONOPHASIC	VELOCITIES CM/S
Common Femoral Artery				
SFA PROX.				
SFA MID.				
SFA DISTAL				
POP ART PROX.				
POP ART. DISTAL				
PTA PROX.				
PTA. MID				
PTA DISTAL				
DPA				

LEFT

	TRIPHASIC	BIPHASIC	MONOPHASIC	VELOCITIES CM/S
Common Femoral Artery				
SFA PROX.				
SFA MID.				
SFA DISTAL				
POP ART PROX.				
POP ART. DISTAL				
PTA PROX.				
PTA. MID				
PTA DISTAL				
DPA				