

## LOWER EXTREMITY VENOUS DOPPLER

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

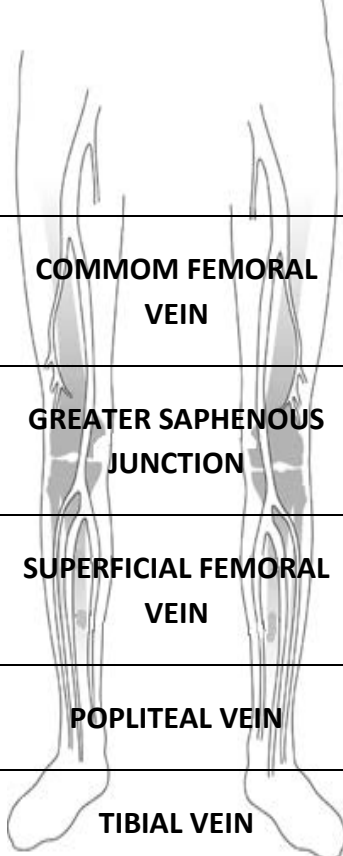
Sonographer: \_\_\_\_\_

TRAUMA: Y / N    EDEMA: Y / N    CALF TENDER: Y / N    PREV. DVT: Y / N

Clinical Indication: \_\_\_\_\_

**RIGHT**

**LEFT**

LUMEN COMPRESSION	COLOR FILLS LUMEN	AUGMENTATION	PARTIAL THROMBUS	COMPLETE THROMBUS		COMPLETE THROMBUS	PARTIAL THROMBUS	AUGMENTATION	COLOR FILLS LUMEN	LUMEN COMPRESSION	
					 <p><b>COMMON FEMORAL VEIN</b></p>						
						<p><b>GREATER SAPHENOUS JUNCTION</b></p>					
						<p><b>SUPERFICIAL FEMORAL VEIN</b></p>					
						<p><b>POPLITEAL VEIN</b></p>					
						<p><b>TIBIAL VEIN</b></p>					

Additional Comments: \_\_\_\_\_

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