UPPER EXTREMITY ARTERIAL DOPPLER

Name: _____ Date: _____

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

Sonographer: _____

SYMPTOMATIC : Right Left **ULCERS/GANGRENE:** No Yes **PULSES:** NORMAL ABNORMAL

Clinical Indication: _____

RIGHT

	TRIPHASIC	BIPHASIC	MONOPHASIC	VELOCITIES CM/S
SUBCLAVIAN ART.				
AXILLARY ART.				
BRACHIAL ARTERY Prox.				
Mid.				
Dist.				
RADIAL ARTERY				
ULNAR ARTERY				

LEFT

	TRIPHASIC	BIPHASIC	MONOPHASIC	VELOCITIES CM/S
SUBCLAVIAN ART.				
AXILLARY ART.				
BRACHIAL ARTERY Prox.				
Mid.				
Dist.				
RADIAL ARTERY				
ULNAR ARTERY				

Additional Comments:_____