UPPER EXTREMITY VENOUS DOPPLER

Name: _____ Date: _____

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

Sonographer: _____

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

Clinical Indications: _____

RIGHT **LEFT**

LUMEN COMPRESSION	COLOR FILLS LUMEN	AUGMENTATION	PARTIAL THROMBUS	COMPLETE THROMUS		COMPLETE THROMUS	PARTIAL THROMBUS	AUGMENTATION	COLOR FILLS LUMEN	LUMEN COMPRESSION
					JUGULAR VEIN					
					SUBCLAVIAN VEIN					
					AXILLARY VEIN					
					BRACHIAL VEIN (HUMERUS)					
					BRACHIAL VEIN (ELBOW)					
					BRACHIAL VEIN (FOREARM)					
					RADIAL VEIN					
					ULNAR VEIN					

Additional Comments: _____

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