Australian ULTRASOUND Specialists

DIAGNOSTIC MEDICAL IMAGING REQUEST FORM

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Name:_____ **Medicare No:**_____

Phone:_____ **Medicare Exp:**____/____ **No:**____

D.O.B.:____/____/_____

(or attach patient identification label)

NON-INVASIVE VASCULAR DIAGNOSTIC IMAGING:

1. ☐ Carotid arterial duplex
   ☐ + Dynamic vertebral arts and veins
2. ☐ Thoracic outlet dynamic duplex (art + vein)
   ☐ + Internal jugular veins
3. ☐ Mesenteric arterial duplex (MALS, SMA syndrome)
4. ☐ Pelvic veins for reflux / compression (Nutcracker, May Thurners, Pelvic congestion)
5. ☐ Popliteal compression study
6. ☐ Lower limb arterial duplex Rt ☐ Lt ☐
   ☐ + Aorto-iliac arteries
7. ☐ Upper limb arterial duplex Rt ☐ Lt ☐
8. ☐ Graft surveillance
9. ☐ Chronic venous insufficiency mapping (Varicose veins) Rt ☐ Lt ☐
10. ☐ Upper limb veins DVT Rt ☐ Lt ☐
11. ☐ Lower limb veins DVT Rt ☐ Lt ☐
12. ☐ Pre-surgical skin marking
13. ☐ Abdominal aortic aneurysm (AAA/Aortic-iliac arteries)
14. ☐ Renal artery duplex
15. ☐ Other study

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CLINICAL INDICATIONS:

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Referring Doctor:_____

Signature:_____

Provider No:_____ **Copy to:**_____ **Date:**____/____/____

☐ **Email:**_____ ☐ **Fax:**_____