



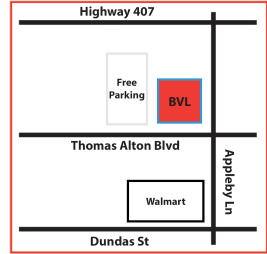
# BURLOAK VASCULAR LAB

**6 "7\ Ub** MD, FRCSC, RPVIA  
*Vascular Surgery*

**8 ">]Ub[** MD, FRCSC, RPVIA  
*Vascular Surgery*

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NAME \_\_\_\_\_ TEL # \_\_\_\_\_

OHIP No: \_\_\_\_\_ D. O. B. \_\_\_\_\_

## REQUEST FOR ASSESSMENT

### PERIPHERAL ARTERIAL

- Carotids
- Aorta & iliacs (Aneurysm Screening)
- Lower extremities bilateral  
(Incl. Aorta, iliacs, ABI, TBI)
- Upper extremities bilateral
- <sup>R</sup>  <sup>L</sup> Lower extremity unilateral
- Upper extremity unilateral

### PERIPHERAL VENOUS

- Lower extremities bilateral  
(with IVC & iliacs)
- Upper extremities bilateral
- <sup>R</sup>  <sup>L</sup> Lower extremity unilateral
- Upper extremity unilateral

**CLINICAL CONSULTATION** Other: \_\_\_\_\_

Clinical Information \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Appointment time: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Billing #: \_\_\_\_\_

Clinic: \_\_\_\_\_ Ph: \_\_\_\_\_ Fax: \_\_\_\_\_