McLaren
MEDICAL GROUP

McLaren Macomb General & Vascular Surgery
38770 Garfield Road Suite 102 Clinton Twp., MI 48038
Phone (586) 421-4204 • Fax (586) 421-4222

DOPPLER REFERRAL

Name: _____

Appointment Date/Time: _____

Referring Physician:_____
❏ Testing Only
❏ Testing and Physician Appointment

REASON FOR VASCULAR TESTING:
❏ Pain ❏ Bruit ❏ Swelling ❏ Ulcer ❏ CVA/TIA
❏ Other:_____

ARTERIAL:
❏ AAA Ultrasound
❏ Carotid Doppler
❏ Raynaud's Evaluation
❏ Renal Artery Ultrasound
❏ Lower Extremity Arterial Doppler
❏ Thoracic Outlet Evaluation
❏ Upper Extremity Arterial Doppler
❏ Pseudoaneuysm Evaluation

VENOUS:
❏ Lower Extremity Venous Doppler
❏ Bilateral ❏ Right ❏ Left

❏ Upper Extremity Venous Doppler
❏ Bilateral ❏ Right ❏ Left