



THUMB REGION

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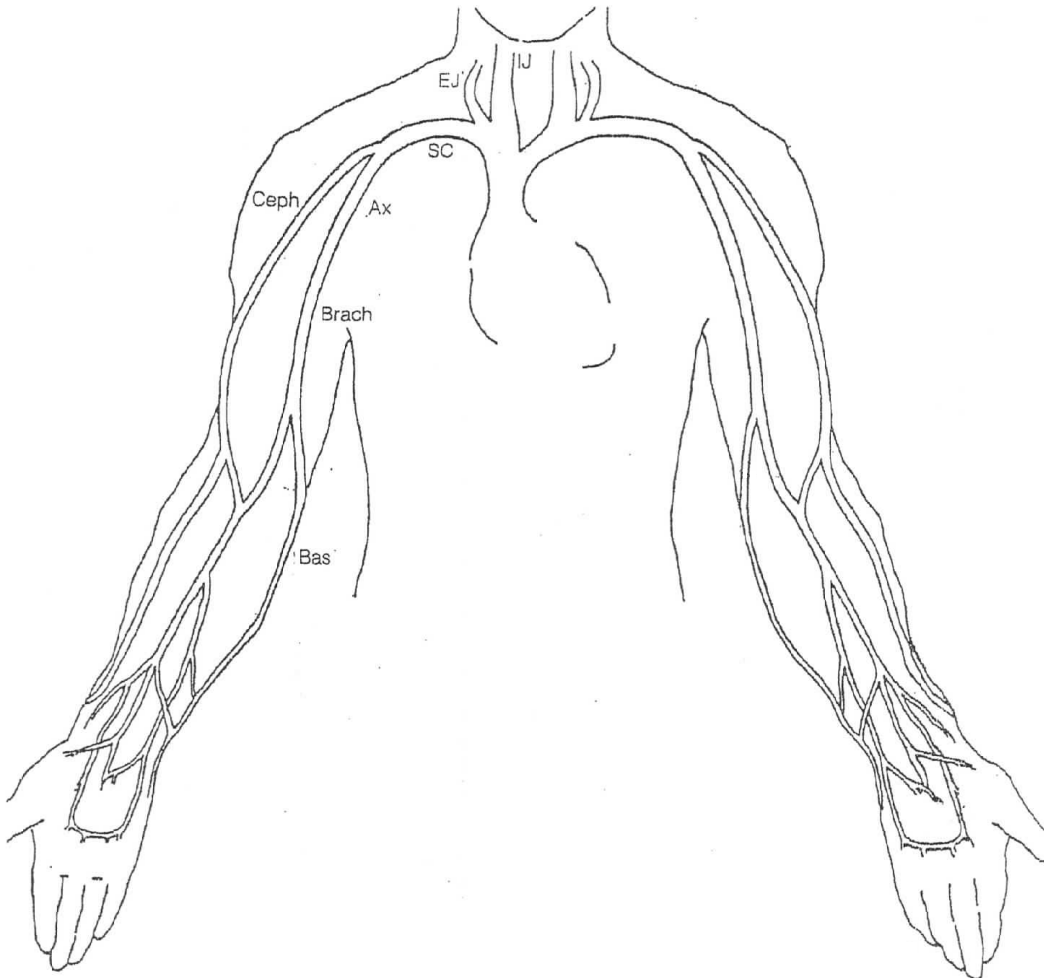
VASCULAR LAB WORKSHEET

Name: _____ Patient #: _____ Date: _____

Physician: _____ Diagnosis: _____

Right: _____

Left: _____



Technician's Signature: _____