McLaren

CARO REGION

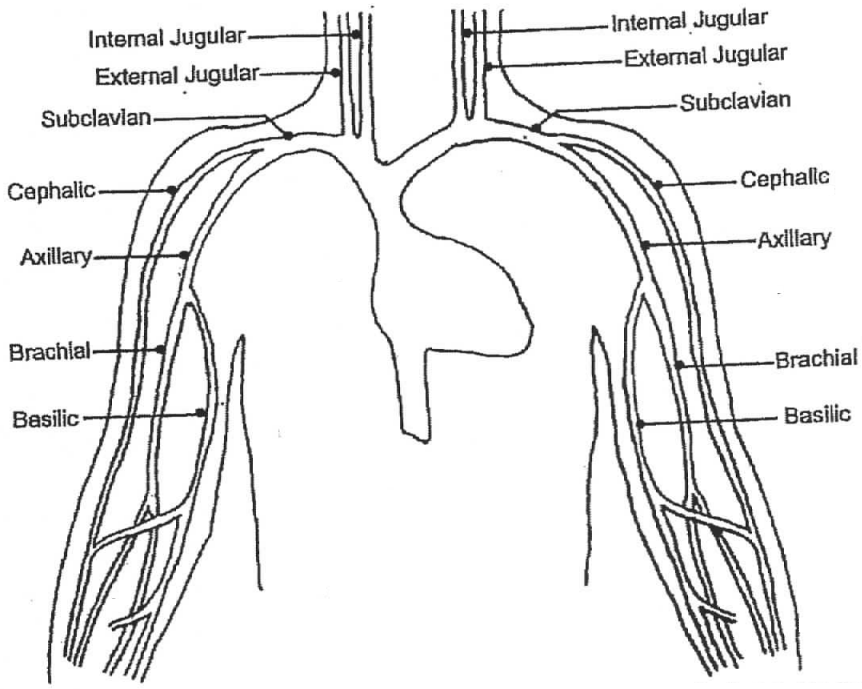
UPPER EXTREMITY VENOUS DOPPLER WORKSHEET

PATIENT NAME: _____ DATE: _____

MR NUMBER: _____ AGE: _____

FAMILY DOCTOR: _____ ORDERING DOCTOR: _____

INDICATION(S): _____



VEIN		COMPRESSIBILITY	
Internal jugular		RIGHT	LEFT
BCV			
Proximal subclavian			
Mid subclavian			
Distal subclavian			
Axillary			
Brachial			
Basilic			
Cephalic			

AUGMENTATION	
RIGHT	LEFT

INSPIRATORY MANEUVER	
RIGHT	LEFT

FINDINGS: _____

_____

TECHNOLOGIST: _____

FORM: US 7
REV: 03-01-16