McLaren

CARO REGION

UPPER EXTREMITY VENOUS EXAM

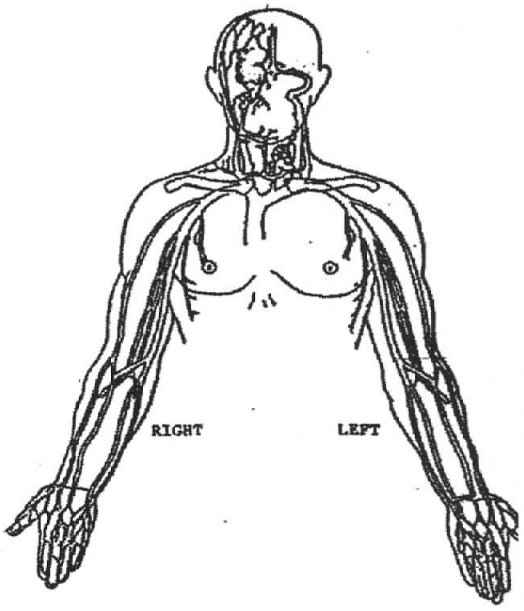
Name:_____ Date:_____

Birth Date:_____ MR#:_____ Physician:_____

Reason for Exam:_____

_____

	Right	Left
Pain	_____	_____
Edema	_____	_____
Temperature Changes	_____	_____
Hx Trauma	_____	_____
DVT Arm	_____	_____ Date:_____
DVT Leg	_____	_____Date:_____



Doppler Evaluation

	PHASIC	AUGMENT
Jugular	RT:_____ LT:_____	RT:_____ LT:_____
Subclavian	RT:_____ LT:_____	RT:_____ LT:_____
Axillary	RT:_____ LT:_____	RT:_____ LT:_____
Brachial	RT:_____ LT:_____	RT:_____ LT:_____
Basilic	RT:_____ LT:_____	RT:_____ LT:_____
Cephalic	RT:_____ LT:_____	RT:_____ LT:_____

IMPRESSION

_____

_____

_____

_____

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Sonographer:_____

FORM: US 17
NEW: 11-20-19