CARO REGION

Lower Extremity Arterial Duplex Evaluation

Name:______________________________ Date:____________ DOB:____________

MR#__________ Referring Physician:____________________

Reason for Exam :____

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Diabetes		Claudication	
Smoking		Numbness/Paresthesia	
HTN		Gangrene	
HLD		Rest Pain	
Cyanosis		Cold Intolerance	
Pallor/Redness		Sores/Ulcers	

RT Brachial		LT Brachial	
RT Upper Thigh		LT Upper Thigh	
RT Above Knee		LT Above Knee	
RT Below Knee		LT Below Knee	
RT Ankle		LT Ankle	
RT ABI		**LT ABI**	

A=Absent M=Monophasic B=Biphasic T=Triphasic Mild/ Mod/ Marked

	Velocity cm/sec	**Waveform**	**Plaque**
RT CFA			
RT Prox FA			
RT Mid FA			
RT Dist FA			
RT POP A			
RT Prox PTA			
RT Dist PTA			
RT ATA			
LT CFA			
LT Prox FA			
LT Mid FA			
LT Dist FA			
LT POP A			
LT Prox PTA			
LT Dist PTA			
LT ATA			

Comments:____

FORM: US 20
NEW: 3-17-20