

SPECIALIST **VASCULAR** ULTRASOUND

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**VASCULAR ULTRASOUND REQUEST**

PATIENT: Call us on 0800 83 46 44 for an appointment. Remember to bring this form with you.

DOCTOR: Either give this form to your patient or send it via EDI Healthlink: veinspec or scan and email to [reception@svh.co.nz](mailto:reception@svh.co.nz).

Personal details

Given name: \_\_\_\_\_ NHI: \_\_\_\_\_

Surname: \_\_\_\_\_

Residential address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Mobile: \_\_\_\_\_

Duplex ultrasound

Carotids  Aorta  Vein mapping

Lower limb arteries  Lower limb venous study  Lower limb DVT

Upper limb arteries  Upper limb venous study  Other test (please discuss): \_\_\_\_\_

Renal arteries  Renal fistula assessment

Pressure studies

Ankle Brachial Indices  Exercise Doppler

Clinical indications

Urgent

Doctor's name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Report by  EDI Healthlink: veinspec  Email: \_\_\_\_\_

Phone: \_\_\_\_\_  Fax: \_\_\_\_\_  Copy to: \_\_\_\_\_

Community radiology  ACC

Insurance  Yes  No Insurance Provider: \_\_\_\_\_

**0800 83 46 44**  
for all inquiries

F 04 389 4970

E [reception@svh.co.nz](mailto:reception@svh.co.nz)

W [www.svh.co.nz](http://www.svh.co.nz)

**WAKEFIELD HOSPITAL  
SPECIALIST CENTRE**

**WELLINGTON**

**PALMERSTON NORTH**

**KAPITI**

**NELSON**

EDI Healthlink:  
veinspec