

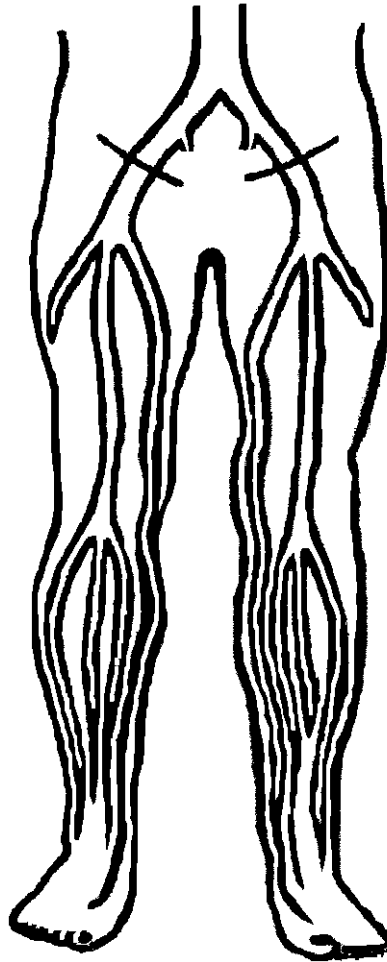
**BROWN-FOLSE PACS, LLC
VASULAR LABORATORY**

Name _____ DOB _____ Physician _____

LOWER EXTREMITY VENOUS DUPLEX TESTING

Presenting Condition _____

RIGHT	Spontaneous	Phasic	Pulsatile	Augmented	Reflux	Compressed
CVF						
G SAPH						
PFV						
SFV						
POP						
CALF PTV						
PERONEAL						
ANKLE PTV						
ANKLE ATV						
ANKLE G SAPH						



Spontaneous	Phasic	Pulsatile	Augmented	Reflux	Compressed	LEFT
						CVF
						G SAPH
						PFV
						SFV
						POP
						CALF PTV
						PERONEAL
						ANKLE PTV
						ANKLE ATV
						ANKLE G SAPH

Comments:

Sonographer _____