



BRAMPTON VASCULAR INSTITUTE

V. Kapila MD, FRCSC, RPVI
Vascular Surgery

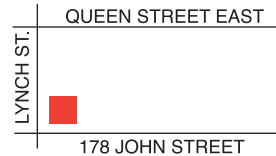
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Interventional Radiology

K. Louis MD, FRCSC
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NAME _____ PT. TEL # _____

OHIP No: _____ D. O. B. _____

REQUEST FOR ASSESSMENT

PERIPHERAL ARTERIAL

- Carotids
- Lower extremities bilateral
(Incl. Aorta, ABI, TBI)
- Upper extremities bilateral

PERIPHERAL VENOUS

- Lower extremities bilateral
(Incl. IVC)
- Upper extremities bilateral
- Venous mapping

ECHOCARDIOGRAPHY
(Incl. M-Mode, 2D and Color Doppler)

AV DIALYSIS GRAFT EXAM

CLINICAL CONSULTATION WITH A SURGEON

OTHER _____

Clinical Information _____

Appointment Time _____

Ref. Doctor (PRINT) _____ M. D.