

**This is NOT an interpretation of the examination.  
See patient dictated report for radiologist findings & impression.**

## Vein Mapping – Lower Extremity

Patient Name: _____
ACC#: _____
MRN#: _____
DOB: _____
Ref Physician: _____

Site: \_\_\_\_\_

Tech/ext: \_\_\_\_\_

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

**Patency of Deep Veins:** Check boxes for all patent vessels. If thrombus is found, comment location and description.

- |                                 |                                 |                                 |                                 |                                 |                                 |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> RT CFV | <input type="checkbox"/> RT FV  | <input type="checkbox"/> RT POP | <input type="checkbox"/> LT CFV | <input type="checkbox"/> LT FV  | <input type="checkbox"/> LT POP |
| <input type="checkbox"/> RT SFJ | <input type="checkbox"/> RT GSV | <input type="checkbox"/> RT SSV | <input type="checkbox"/> LT SFJ | <input type="checkbox"/> LT GSV | <input type="checkbox"/> LT SSV |

Comments:

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Right	Left
<b><u>GSV Diameter (mm)</u></b>	<b><u>GSV Diameter (mm)</u></b>
Thigh Proximal _____	Thigh Proximal _____
Thigh Mid _____	Thigh Mid _____
Thigh Distal _____	Thigh Distal _____
Calf Proximal _____	Calf Proximal _____
Calf Mid _____	Calf Mid _____
Calf Distal _____	Calf Distal _____
<b><u>SSV Diameter (mm)</u></b>	<b><u>SSV Diameter (mm)</u></b>
Proximal _____	Proximal _____
Mid _____	Mid _____
Distal _____	Distal _____

Comments:

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