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**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Phone: \_\_\_\_\_  
Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Appointment Time: \_\_\_\_\_

**REFERRING PHYSICIAN**

Name: \_\_\_\_\_  
Other Phone: \_\_\_\_\_  
 Phone Report  Mail Report  Fax Report to: \_\_\_\_\_

**VENOUS ULTRASOUND OR CONSULTATION FOR VENOUS DISEASE REQUESTED**

Consultation \_\_\_\_\_  
 Venous Ultrasound for Reflux (Please circle): Right Left Bilateral  
 Venous Ultrasound for DVT (Please circle): Right Left Bilateral  
 Varicose Veins  
 Venous Stasis Ulcer  
 Spider Veins  
 Conservative Therapy (i.e., compression stockings) instituted already?  Yes  No

**DIAGNOSIS**

Greater Saphenous Vein Reflux  
 Chronic Venous Insufficiency  
 Stasis Dermatitis  
 Restless Leg Syndrome  
 Bulging Veins on Legs  
 Spider Veins  
 Varicose Veins  
 Leg Ulcer  
 Burning / Tingling Sensations  
 Heaviness & Fatigue  
 Skin Discoloration / Texture Change  
 Other: \_\_\_\_\_  
 Swelling / Throbbing  
 Cramping / Pain

**CLINICAL HISTORY & ADDITIONAL COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_