

# UPPER EXTREMITY DUPLEX

Patient Name: \_\_\_\_\_

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

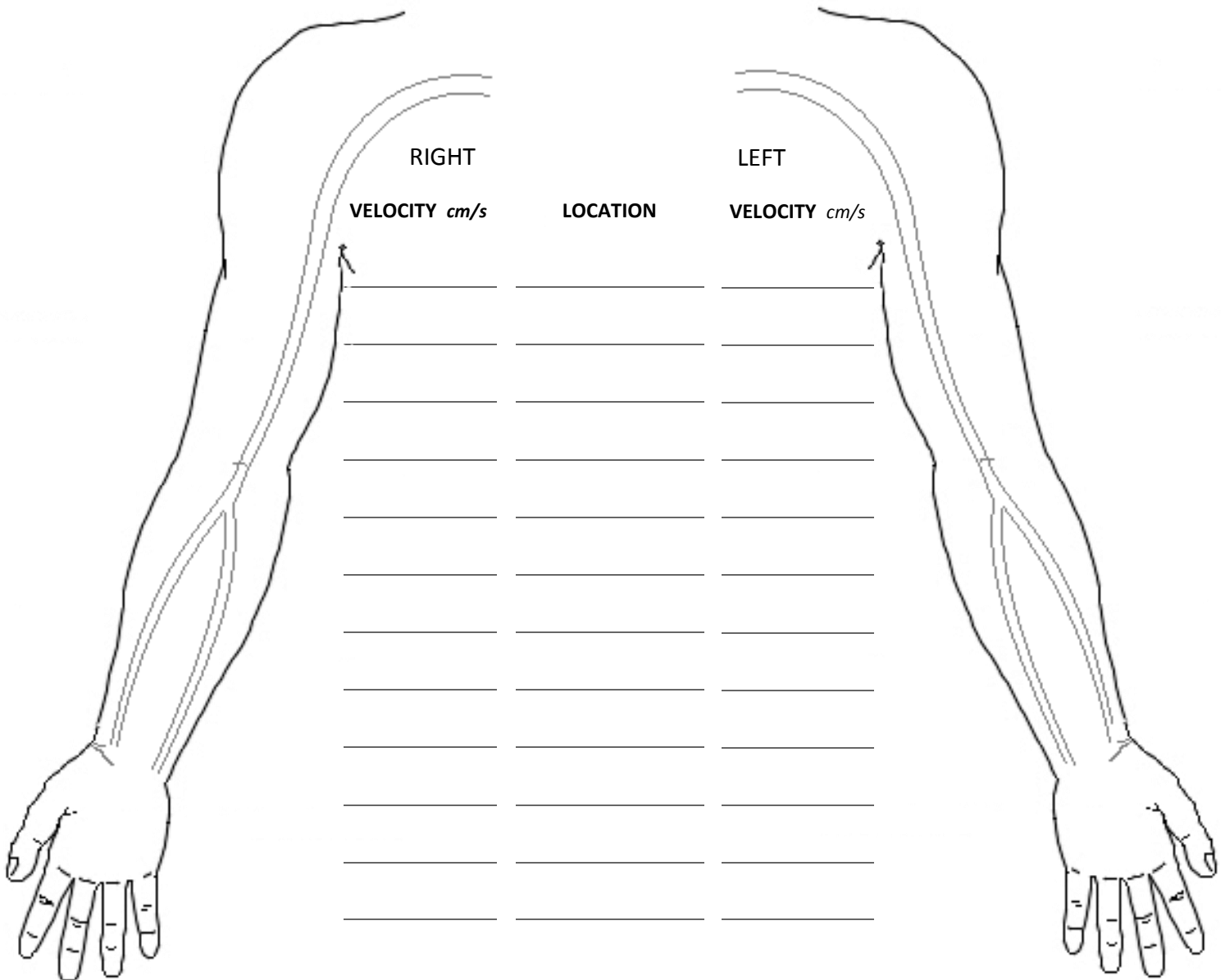
MRN: \_\_\_\_\_

Tech: \_\_\_\_\_

DOB: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_

Indication: \_\_\_\_\_



Comments: \_\_\_\_\_

\_\_\_\_\_

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