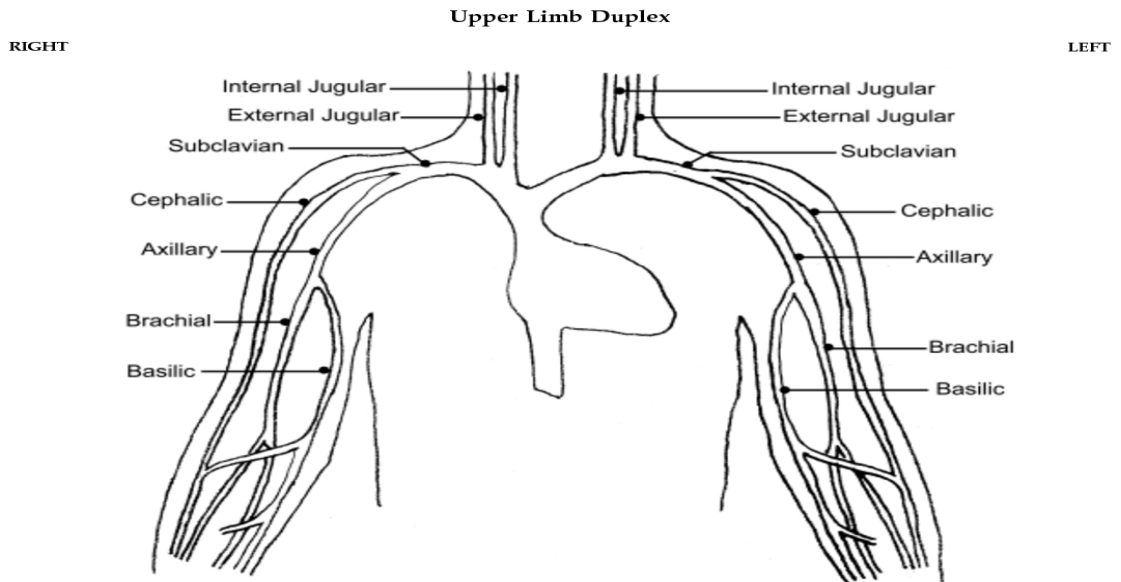


DRAFT UPPER LIMB VENOUS WORKSHEET

SONOGRAPHER PATIENT NAME
SONOLOGIST EPISODE/Accession No
Date . . . / . . . /200 DOB . . . / . . . / MRN/URN
Indications for study
Findings and Comments



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