Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

Referring Physician: [Doctor Name]
Consulting Specialist: [Specialist Name]

Subject: Specialist Vein Mapping Consultation Summary

Clinical Indication:
[Reason for mapping, e.g., Pre-operative evaluation for CABG, AV Fistula creation, or Varicose Vein assessment]

Procedure Performed:
Duplex Ultrasound Vein Mapping of the [Left/Right/Both] [Upper/Lower] Extremities.

Key Findings:

- **Deep Venous System:** [Patent / No evidence of DVT / Observations]
- **Superficial Venous System:** [Great Saphenous Vein (GSV) / Small Saphenous Vein (SSV) measurements and patency]
- **Vein Diameters:** [List specific diameters at proximal, mid, and distal points]
- **Anatomical Variations:** [Note any duplications, tortuosity, or superficial depth issues]

Impression:
[Summary of the suitability of the veins for the intended procedure]

Recommendations:
[Follow-up actions or surgical planning suggestions]

Sincerely,

[Signature]
[Specialist Name]
[Title/Department]
[Facility Name]