Reference Request to Vascular Consultant

**Applicant’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The above named applicant has applied to sit the SVT practical examination. This is the final assessment on the route to becoming an Accredited Vascular Scientist. Applicants must fulfil certain eligibility criteria before they are entitled to sit the examination. The applicant has proposed that as their Vascular Consultant you can help confirm their eligibility. We would be grateful if you could fill in the details below.

|  |  |  |
| --- | --- | --- |
| Applicants current job title |  |  |
| Applicants current Employer/Hospital |  |
| Start date of applicants current job |  |
| Applicants current weekly hours working in vascular ultrasound diagnostic scanning |  |
| How long have you known the applicant? |  |

**Where applicable please comment on your perception of the applicant’s proficiency in the following areas:**

Duplex of carotid and vertebral arteries Poor Acceptable Good Excellent

Duplex of lower limb arteries Poor Acceptable Good Excellent

Duplex of varicose veins Poor Acceptable Good Excellent

Ankle Brachial Pressure Indices Poor Acceptable Good Excellent

**Please comment on the applicant’s ability to write clear reports and relay urgent findings appropriately:**

**Please include any other comments you may have (please continue on the reverse of the page if required).**

**Email Address**.……………………………………………………………………………………………………………………………………………………………………………

**Signed**……………………………………………………..………………… **Print Name**…………………………………………………………………………………………..

**Designation**………………………………………………………………………………………………………………………………………………………………………..…….….

**Date**…………………………………………………………….……………..

By signing this form you consent for your information to be uploaded to the SVTGBI website and for the SVTGBI to contact you in regards to this reference.