Patient Label
Patient Name

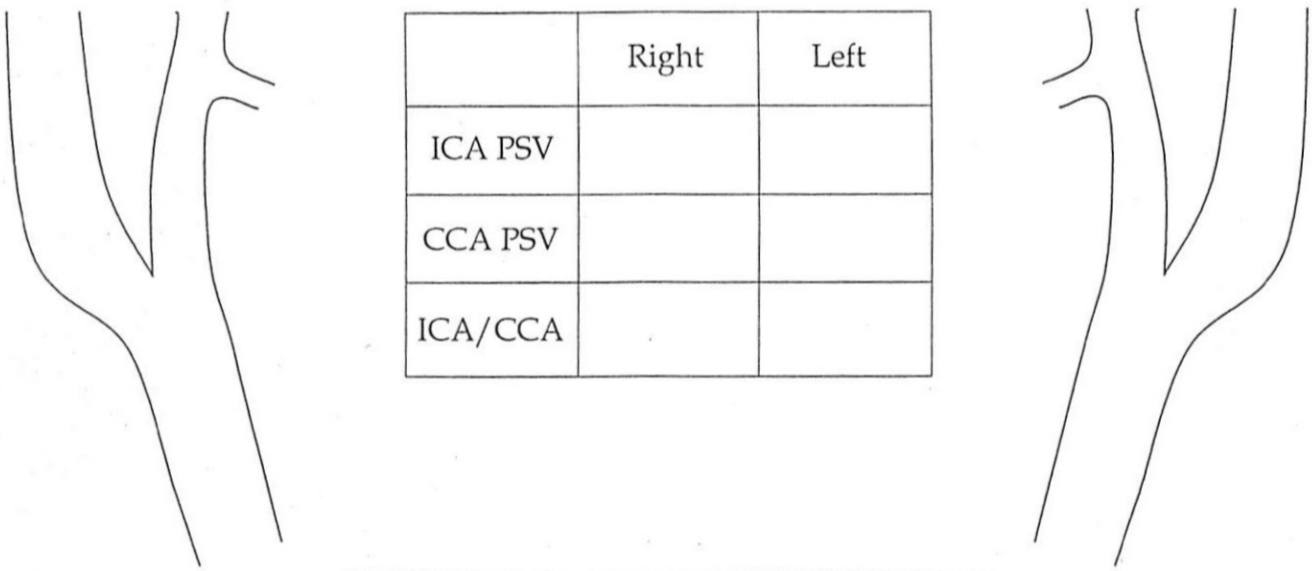
_____

MR#_____

Carotid Doppler Worksheet

History: (Indicate **R**, **L**, or **B** in all blanks that apply)

___ TIA/Amaurosis Fugax
___ Unexplained Syncope
___ CVA
___ Visual Disturbance
___ Speech Disturbance
___ Gait Abnormality/Vertigo
___ Hemiplegia/Paraplegia
___ Carotid Stenosis/Bruit
___ Polyarteritis
___ Post-operative Follow-up
___ Pre-operative Exam
___ Cerebral Artery Occlusion
___ Other: _____
_____



	Right	Left
ICA PSV		
CCA PSV		
ICA/CCA		

Vertebral Artery	Right	Left
Anterograde		
Retrograde		
Not Found		

Comments: _____

_____

_____

Technologist: _____ **Radiologist:** _____

SYNERGY
RADIOLOGY ASSOCIATES