CAROTID DOPPLER

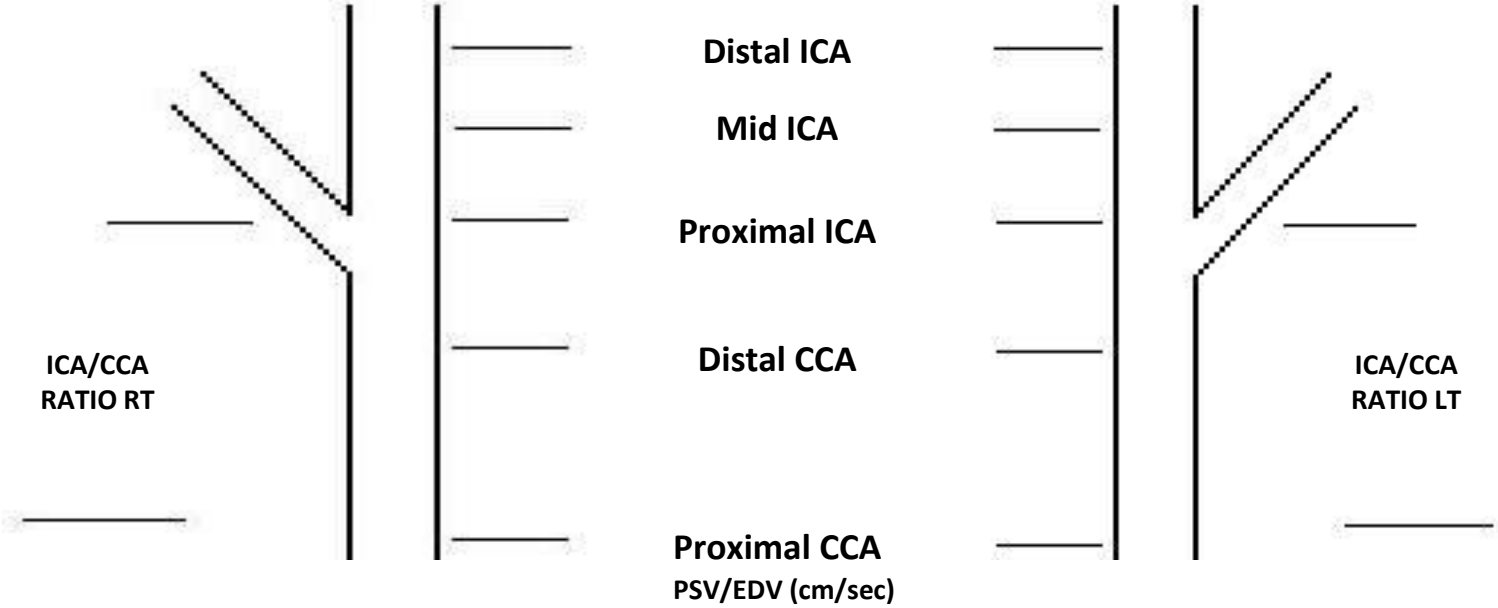
Name: _____ Date: _____

Physician: _____ DOB: ____/____/_____ Age: _____

Sonographer: _____

SYMPTOMATIC: R / L HX OF STROKE: Y / N HX OF CAROTID SURGERY: Y / N L / R

Clinical Indications: _____



RT VERTEBRAL: **Antegrade** **Reversed** **LT VERTEBRAL:** Antegrade Reversed

Degree of Stenosis (%)	ICA PSV (cm/sec)	EDV (cm/sec)	PSV Ratio
NL- Mild: <50	< 125		<2.0
Moderate: 50-69	125-225		>2.0
Severe: 70-90	225-325	< 140	> 3.0
Critical: >90	> 325	> 140	> 4.0
Occluded	No Flow	No Flow	