Radiology Associates
of the Fox Valley
333 N. Commercial Street, Neenah, WI

Patient Information Form (PIF) for Carotid Bruit

The following patient information forms are used for patients undergoing imaging of the carotid bruit.

The first form, titled "Carotid Ultrasound Worksheet", is used carotid ultrasound examinations.

The second form, titled "Brain", is used for CTA (computed tomographic angiography) and MRA (magnetic resonance angiography) of the carotids, since these patients typically have neurologic symptoms and frequently undergo simultaneous brain imaging.

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Patient Name: _____ Previous exam: _____
Date of birth: _____ Technologist: _____

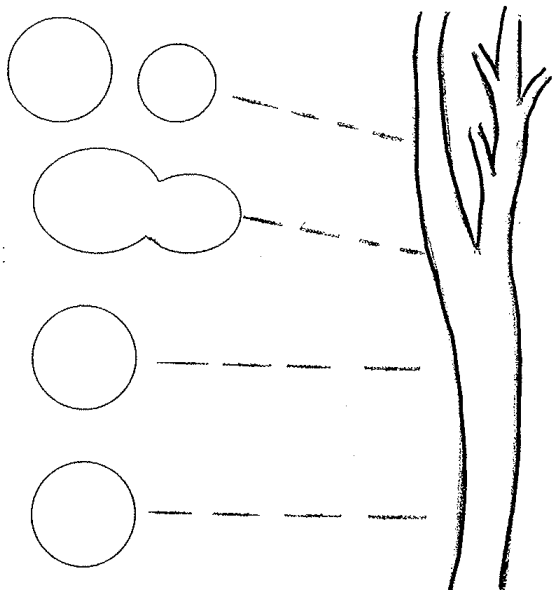
CAROTID ULTRASOUND WORKSHEET

Ordering Physician:_____

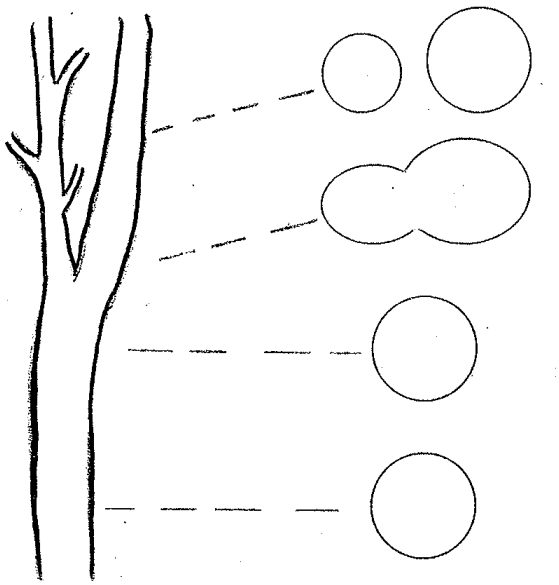
Reason for exam (Payable) ☐ Stenosis ☐TIA ☐CVA ☐Syncope ☐Lack of coordination ☐Speech disturbance ☐ Bruit

Other (Non-payable) _____

Right



Left



	Right	Left
CCA PSV cm/sec		
CCA EDV cm/sec		
ICA PSV cm/sec		
ICA EDV cm/sec		
ICA / CCA PSV Ratio		
ICA / CCA EDV Ratio		
Visual Plaque Est.		
Vertebral Artery Flow		
ECA PSV cm/sec		

Primary Parameters			**Additional Parameters**	
Degree of Stenosis %	ICA PSV cm / sec	Plaque Estimate	ICA / CCA PSV Ratio	ICA EDV cm / sec
Normal	<125	None	<2 . 0	<40
<50	<125	< 50	<2 . 0	<40
50 – 69	125 – 230	>50	2 . 0 – 4 . 0	40 – 100

Other comments:_____

☐ Routine, no immediate call back necessary ☐ ***Call report to:***_____

Number or Pager: _____

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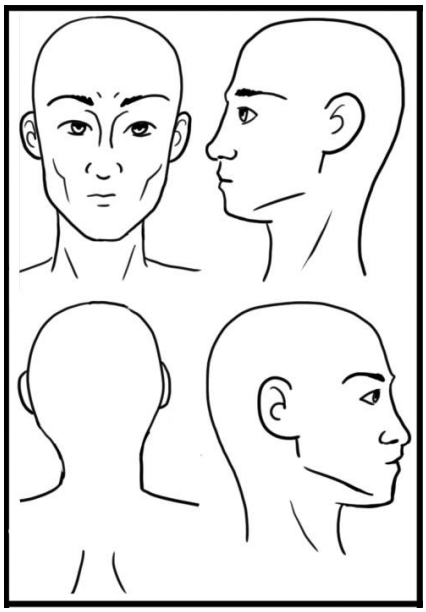
Patient Name: _____ Previous exam: _____
Date of birth: _____ Technologist: _____

Brain

Please mark the location of any pain:



How long have you had your symptoms?	
Have you had prior surgery done on your head/brain? If so, please tell us the approximate date(s) and procedure(s):	
Please check if you have any of the following:	
	Nausea and/or vomiting.
	Dizziness.
	Arm weakness or numbness. Circle one: Left, right or both.
	Leg weakness or numbness. Circle one: Left, right, or both.
	Blurred vision. Circle one: Left eye, right, eye, both.
	Ringing in the ears. Circle one: Left ear, right ear, both.
	Hypertension.
	Strokes.
	Brain tumor. If so, what kind?

If your pain was caused by trauma/injury, please describe how you were injured:

Headache patients, please check all that apply (pick one column):

	NEW OR DIFFERENT HEADACHE		RECURRENT/REPEATED HEADACHE
	This is the worst headache I've ever had.		Light or sound makes my headaches worse.
	This is the first headache I've ever had.		My headaches get worse with physical activity
	My neck feels stiff.		My headaches have a throbbing quality.
	I have sinus congestion and/or drainage.		My headaches only involve one side of my head.
	Headache that changes with my posture.		Headache that changes with my posture.

For those with recurrent/repeated headache, how long do your headaches usually last? _____

Have you ever been diagnosed with cancer? YES NO

If yes, what type? _____

FOR TECHNOLOGIST USE ONLY (Fluoro time: ____ or NA)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details: