Cerebrovascular Examination Procedure Request

Cerebrovascular Laboratory, Department of Neurological Surgery
Harborview Medical Center
Harborview Box 359970 - East Clinic, 1st Floor, Rooms 12-17, Seattle, WA 98104

IMPORTANT	Please telephone all requests to 206-744-3905	Date:
	Please FAX all request forms to 206-744-8512	Time:

DIAGNOSTIC TESTS

- ☐ Carotid duplex scan of extracranial arteries, complete
- ☐ Carotid duplex scan of extracranial arteries, limited
- ☐ Transcranial Doppler/transcranial imaging
- ☐ Transcranial Doppler/transcranial imaging, limited
- ☐ Emboli monitoring–specify vessel/vessels_____
- ☐ CO_2 challenge test for vasomotor reactivity
- ☐ Autoregulation test for vasomotor reactivity
- ☐ Head rotation test for extrinsic compression of the vertebral arteries
- ☐ Monitoring during stent placement-specify vessel_____
- ☐ Agitated Saline study for detection of patent foramen ovale
  - ☐ Insert IV saline lock and discontinue prior to discharge
- ☐ Reactive Hyperemic Test for Subclavian Steal Syndrome
- ☐ Graft Imaging Protocal-specify side: ☐ right ☐ left ☐ bilateral
- ☐ Intraoperative monitoring
  - ☐ Carotid endarterectomy
  - ☐ Other–specify _____
- ☐ Baseline Transcranial Doppler with test occlusion - specify vessel/vessels _____

INDICATIONS, CLINICAL INFORMATION

ORDERING PHYSICIAN SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME
ATTENDING PHYSICIAN SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME

PT.NO

NAME

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CEREBROVASC EXAM PROCEDURE REQUEST

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