ICSS ULTRASOUND FORM

Centre ____

Investigator ____

ICSS No __ __ __ __

Patient's Family Name ______________________ Forename ______________________

Patient's DoB __ __/__ __/__ __
day/month/year

DATE OF ULTRASOUND: __ __/__ __/__ __
day/month/year

	Right carotid artery	**Left carotid artery**
CCA PSV		
ICA PSV		
ICA EDV		

Form completed by (PRINT) ________________________________ Date __ __/__ __/__ __

day/month/year

PLEASE POST OR FAX THIS FORM TO THE ICSS OFFICE
TOGETHER WITH COPIES OF THE ULTRASOUND REPORT

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