SUNY DOWNSTATE Medical Center | Department of Neurology

NEUROVASCULAR LABORATORY

REQUEST FOR NEUROVASCULAR STUDY

DATE OF REQUEST: ____________________

NAME OF PATIENT: ____

DATE OF BIRTH: ___________________ AGE OF PATIENT: ____________

MEDICAL RECORD #:_________________ LOCATION: __________________

TYPE OF STUDY REQUESTED:

☐ Duplex study of extracranial arteries

☐ Transcranial Doppler study of intracranial arteries

HISTORY:

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MEDICATIONS: ____

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NAME OF REFERRING PHYSICIAN: ___________________________________

SIGNATURE: ____

STATE UNIVERSITY OF NEW YORK HEALTH SCIENCE CENTER AT BROOKLYN
450 Clarkson Avenue, Box 118, Brooklyn, NY 11203.