X-RAY ASSOCIATES

NOT A REPORT - SONOGRAPHER'S COMMENTS ONLY

Pt. Name:
Pt. ID:
DOB
Sex:

Date of Exam:
Referring:
CC:

NECK ULTRASOUND

☐ Patient Identity and Referring Physician Confirmed

PREV ☐ Yes ☐ No ☐ MH ☐ SRHC ☐ OTHER

Clinical History:

RT PAROTID GLAND: x x _____ cm

☐ Normal ☐ Abnormal

RT SUBMANDIBULAR GLAND: x x _____ cm

☐ Normal ☐ Abnormal

LT PAROTID GLAND: x x _____ cm

☐ Normal ☐ Abnormal

LT SUBMANDIBULAR GLAND: x x _____ cm

☐ Normal ☐ Abnormal

COMMENTS:

_____ DMS