X-RAY ASSOCIATES

NOT A REPORT - SONOGRAPHER'S COMMENTS ONLY

Pt. Name:
Pt. ID:
DOB:
Sex:

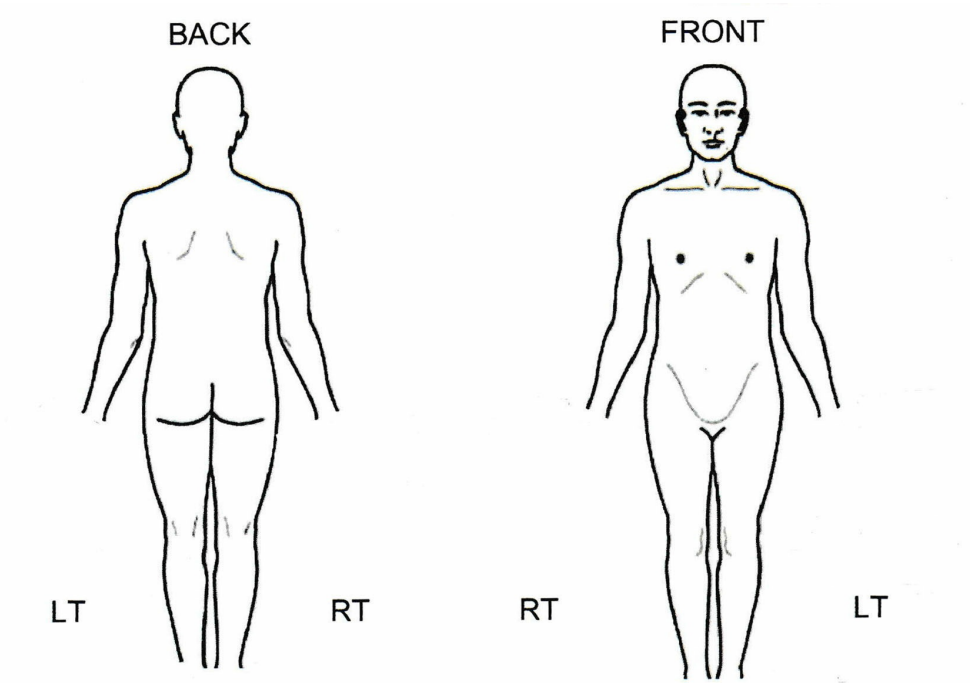
Date of Exam: 2
Referring:
CC:

SOFT TISSUE ULTRASOUND

☐ **Patient Identity and Referring Physician Confirmed**

PREV ☐ Yes ☐ No ☐ MH ☐ SRHC ☐ OTHER

Clinical History:



COMMENTS:

_____ DMS