X-RAY ASSOCIATES

NOT A REPORT - SONOGRAPHER'S COMMENTS ONLY

Pt. Name: **Date of Exam: Referring:**
Pt. ID:
DOB
Sex:

ABDOMEN ULTRASOUND

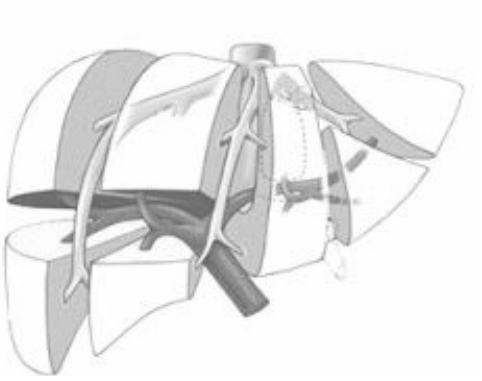
☐ **Patient Identity and Referring Physician Confirmed**

Prev Y ☐ N ☐ MH ☐ SRHC ☐ OTHER ☐ _____

Clinical History:

LIMITED PELVIS Y ☐ N ☐

LIVER: _____ cm



_____

GALLBLADDER:

_____

Murphy's Sign ☐ +ve ☐ -ve

Wall thickness _____ cm

CBD: _____ mm _____

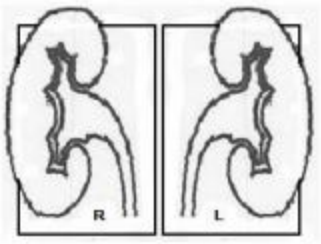
SPLEEN: _____ cm

_____

PANCREAS:

_____

AORTA: ☐ AAA AP _____ cm _____



RIGHT KIDNEY: _____ cm _____

LEFT KIDNEY: _____ cm _____

BLADDER: _____

RLQ ☐ LLQ ☐

FREE FLUID: Y ☐ _____ N ☐

Comments:

_____ DMS