AORTA ULTRASOUND

Name: _____ Date: _____

Physician: _____ DOB: ____/____/_____ Age: _____

Sonographer: _____

Clinical Indications: _____

PROXIMAL: AP: _____ TRANS: _____ X _____

_____

MID: AP: _____ TRANS: _____ X _____

_____

DISTAL: AP: _____ TRANS: _____ X _____

_____

RT ILIAC: AP: _____ TRANS: _____ X _____

LT ILIAC: AP: _____ TRANS: _____ X _____

Additional comments: _____

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