RENAL ULTRASOUND

Name: _____ Date: _____

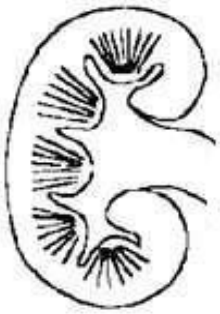
Physician: _____ DOB: ____/____/_____ Age: _____

Sonographer: _____

Clinical Indications: _____

_____

RT



_____ CM _____CM _____CM

LONG AP TRANS

CORTEX _____ CM RI _____

ECHOGENICITY: NORMAL HYPER HYPO

CONTOUR: SMOOTH LOBULATED

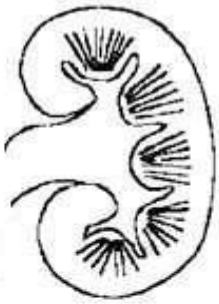
HYDRONEPHROSIS: NO YES

COMMENTS: _____

_____

_____

LT



_____ CM _____CM _____CM

LONG AP TRANS

CORTEX _____ CM RI _____

ECHOGENICITY: NORMAL HYPER HYPO

CONTOUR: SMOOTH LOBULATED

HYDRONEPHROSIS: NO YES

COMMENTS: _____

_____

_____

URINARY BLADDER: Pre Void Volume (ml): _____ Post Void Volume (ml):_____

_____

Additional Comments: _____

*******Any lesion which is measured must have image documentation of color Doppler flow**********