South Georgia Radiology Associates

TESTICULAR ULTRASOUND

Name: _______________________________ Date: ___________________
Physician: ________________________ DOB: ____/____/_______ Age: ______
Sonographer: ____________________________

Clinical Indications: ____

Rt Testicle: _______ cm (length) __________ cm (AP) ___________ cm (trans)

Rt Epididymal Head: ______cm (length) _______cm (AP) _________cm (trans)

Hydrocele : NO YES

____

____

Lt. Testicle: ___________ cm (length) __________ cm (AP) ___________ cm (trans)

Lt Epididymal Head: _________ cm (length) ________ cm (AP) _________ cm (trans)

Hydrocele: NO YES

____

____

Color Flow: **Symmetrical** **Asymmetrical**

____

____

Additional Comments:

____

____

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