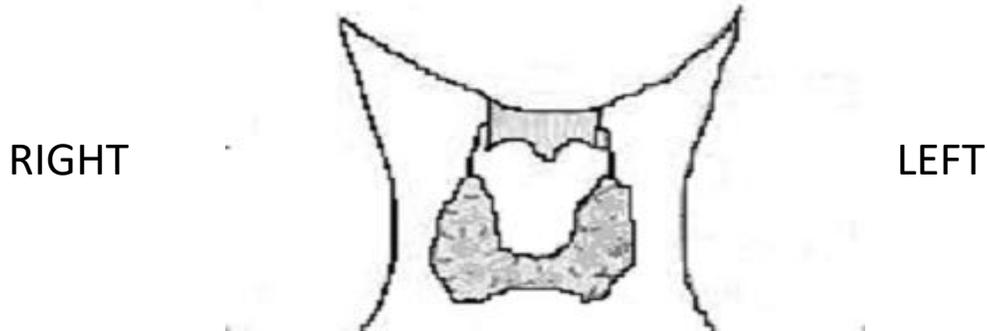


THYROID ULTRASOUND

Name: _____ Date: _____
 Physician: _____ DOB: ___/___/___ Age: _____
 Sonographer: _____

Clinical Indication: _____



_____ CM _____ CM _____ CM
 LONG AP TRANS

COMMENTS: _____

Jugular Adenopathy: NO YES

_____ CM _____ CM _____ CM
 LONG AP TRANS

COMMENTS: _____

Jugular Adenopathy: NO YES

ISTHMUS: _____ CM _____

Additional comments: _____

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