RENAL ULTRASOUND

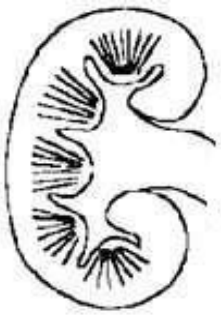
Name: _____ Date: _____

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

Sonographer: _____

Clinical Indications: _____

RT



_____ CM _____CM _____CM
LONG AP TRANS

CORTEX _____ CM RI _____

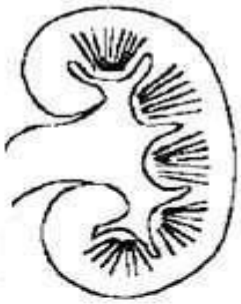
ECHOGENICITY: NORMAL HYPER HYPO
CONTOUR: SMOOTH LOBULATED
HYDRONEPHROSIS: NO YES

COMMENTS: _____

_____

_____

LT



_____ CM _____CM _____CM
LONG AP TRANS

CORTEX _____ CM RI _____

ECHOGENICITY: NORMAL HYPER HYPO
CONTOUR: SMOOTH LOBULATED
HYDRONEPHROSIS: NO YES

COMMENTS: _____

_____

_____

*****When MEASURING Kidney with Exophytic Cyst, Be SURE to MEASURE RENAL PARENCHYMA and not include the cyst on one of the images. *Any lesion which is measured must have image documentation of color Doppler flow.**

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

_____

Additional Comments: _____