Ultrasound Test

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Medical Record Number: _____ Referring Physician: _____

Clinical History:

PREPARATION

Patient Preparation:

ULTRASOUND EXAMINATION DETAILS

Abdominal: _____ Pelvic: _____

Obstetric: _____ Vascular: _____

Musculoskeletal: _____ Other (specify): _____

Linear: _____ Convex: _____

Transvaginal: _____ Doppler (if applicable): _____

Abdomen: _____ Liver: _____

Gallbladder: _____ Kidneys: _____

Bladder: _____ Uterus: _____

Ovaries: _____ Vascular Structures: _____

Other (specify): _____

Imaging Protocol:

FINDINGS

Preliminary Findings:

Final Interpretation:

Recommendations:

Conclusion:

TECHNOLOGIST / PHYSICIAN SIGNATURE

Name: _____ Credentials: _____

Date: _____ dd / mm / yyyy

Quality Assurance: