IMAGEN

# AAA Screening ULTRASOUND EVALUATION

Date of Exam: Name of Patient:

Patient ID #: Accn# Ordering Provider:

Order Status:
- ☐ Regular
- ☐ STAT

Reason for Exam (Symptoms/Indication): Choose or Type

Past Relevant Surgical History: Choose or Type

Past Relevant Medical History: Choose or Type

Previous Relevant Exams & Dates: Choose or Type _____ Date Choose or Type _____ Date Choose or Type _____ Date

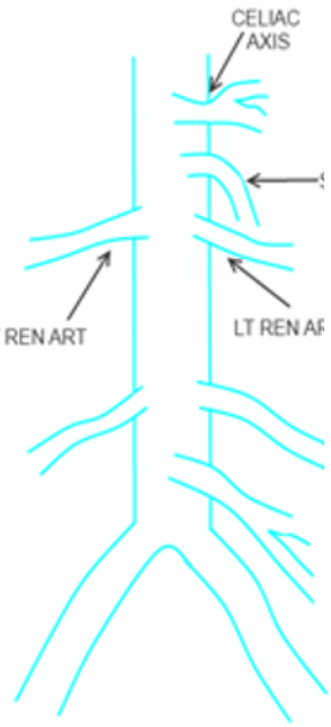
| Impression: | A/P | | Width | |
|---|---|---|---|---|
| Aorta Prox | X | cm | | Please Select One |
| Aorta Mid | X | cm | | Please Select One |
| Aorta Dist | X | cm | | Please Select One |
| Rt Iliac | X | cm | | Please Select One |
| Lt Iliac | X | cm | | Please Select One |

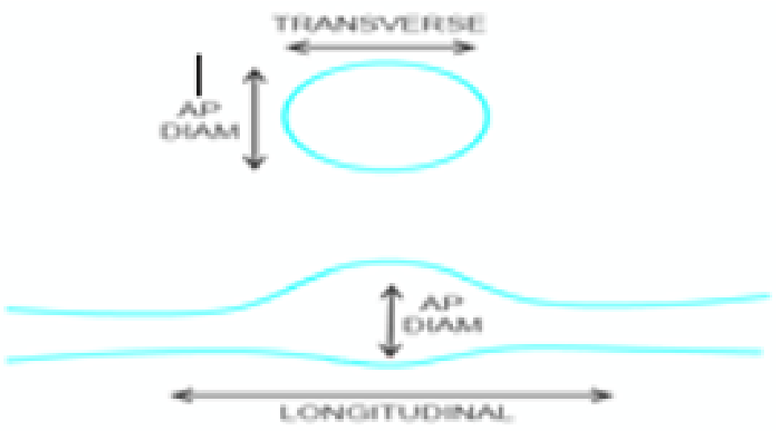
IF AAA seen, document Sag length of involvement:

AAA Seen: ☐ Y ES ☐ NO

Location: ☐ *Infrarenal* ☐ *Suprarenal* ☐ *Renal Arteries NOT S E EN*

*Label AAA location on diagram with an* ✦




*Measurements should INCLUD E the Wall!*

Additional Comments:

Sonographer Name: Contact Phone Number: