IMAGEN

ABDOMINAL LUQ 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:

IVC			cm	Please Select One
Aorta Prox			cm	Please Select One
Aorta Mid			cm	Please Select One
Aorta Dist			cm	Please Select One
Lt Kidney	x	x	cm	Please Select One
Spleen	x	x	cm	Please Select One

Additional Comments:

Sonographer Name: Contact Phone Number: