ABDOMINAL RUQ 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

Pancreas Head	_____	cm	Please Select One
Liver	_____	cm	Please Select One
Gallbladder wall	_____	cm	Please Select One
CBD	_____	cm	Please Select One
Rt Kidney	x x _____	cm	Please Select One

Please Select or Free Text

Additional Comments:

Sonographer Name: Contact Phone Number: