IMAGEN

Aorta Duplex 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

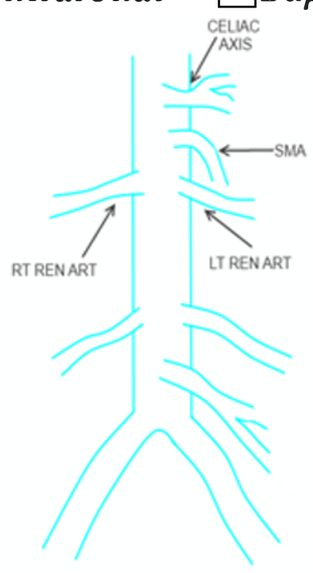
Previous Relevant Exams & Dates: Choose or Type _____ Date Choose or Type _____ Date Choose or Type _____ Date

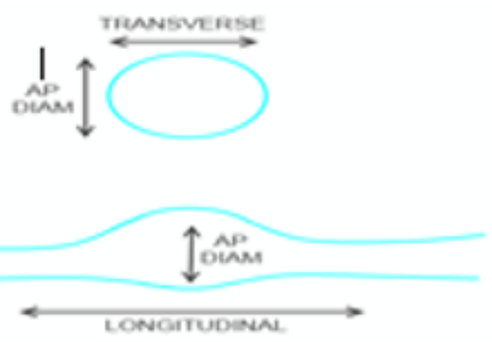
Impression:

Aorta Prox	cm/s	cm	Please Select One
Aorta Mid	cm/s	cm	Please Select One
Aorta Dist	cm/s	cm	Please Select One
Rt Iliac	cm/s	cm	Please Select One
Lt Iliac	cm/s	cm	Please Select One

AAA Seen: ☐Y ES ☐NO Plaque Seen: ☐Y ES ☐NO

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





Measurements should INCLU D E the Wall!

Additional Comments:

Sonographer Name: Contact Phone Number: