IMAGEN

Bladder 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

Bladder Pre-Void _____ Vol Please Select One

Bladder Post-Void _____ Vol Please Select One

Residual Volume:

Post Void / Pre-void x 100 = _____ %

Prostate (*if seen, male patients only*): x x _____ cm Please Select One

Additional Comments:

Sonographer Name: Contact Phone Number: