RETROPERITONEAL (Renal) 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

Aorta Prox	_____	cm	Please Select One
Aorta Mid	_____	cm	Please Select One
Aorta Dist	_____	cm	Please Select One
Rt Kidney	x x	cm	Please Select One
Lt Kidney	x x	cm	Please Select One
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: