ABDOMINAL 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
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
Lt Kidney	x x	cm	Please Select One
Spleen	x x	cm	Please Select One

Please Select or Free Text

Murphy Sign Present Yes ☐ No ☐

Additional Comments:

Sonographer Name: Contact Phone Number: