PRE-OP ARM MAPPING FOR A/V FISTULA TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

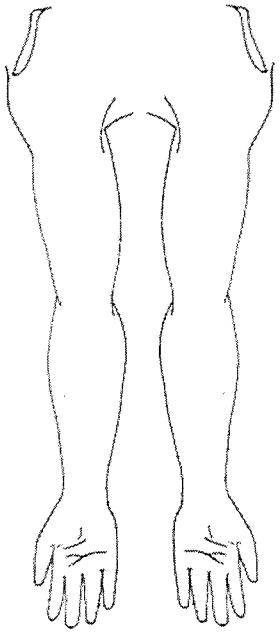
MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

LT

	Cephalic vein (mm)		Basilic Vein (mm)	
	Diam	Depth	Diam	Depth
Prox				
Mid				
Distal				
Antecube				
Prox Forearm				
Mid Forearm				
Distal Forearm				



	Cephalic vein (mm)		Basilic vein (mm)	
	Diam	Depth	Diam	Depth
Prox				
Mid				
Distal				
Antecube				
Prox Forearm				
Mid Forearm				
Distal Forearm				

Comments_____TECH_____

A/V FISTULA EVALUATION TECHNICAL WORKSHEET

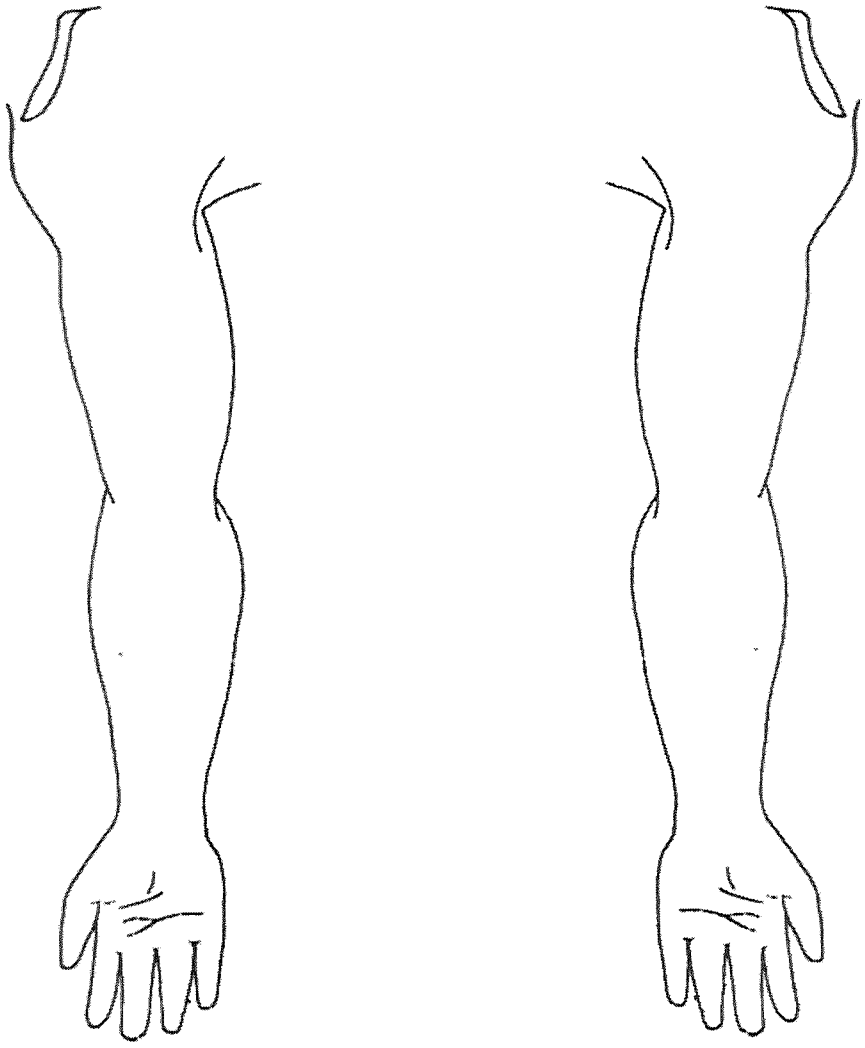
DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

DATE OF A/V FISTULA PLACEMENT_____



Comments_____TECH_____

ABDOMINAL ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

PANCREAS

Parenchyma

Echogenicity	nl	abnl
Size	nl	abnl
Duct	nl	abnl
Masses	N	Y
Calcifications	N	Y

AORTA

Size nl abnl

Prox: _____ x _____ x _____ cm
Mid: _____ x _____ x _____ cm
Distal: _____ x _____ x _____ cm

LIVER

Parenchyma

Echogenicity	nl	abnl
SIZE _____ cm	nl	abnl
Masses (Solid/Cystic)	N	Y
Calcifications	N	Y

_____ x _____ x _____ cm

Vascular

Portal vein	nl	abnl
Splenic Vein	nl	abnl
IVC	nl	abnl

Hepatic Artery nl abnl
Hepatic veins nl abnl

Bile Ducts

Extrahepatic	nl	abnl
Intrahepatic	nl	abnl

CBD _____mm

GALLBLADDER

Morphology

Wall_____mm
Length _____cm
Murphy's sign Neg Pos

Surgically removed N Y
Pericholecystic fluid N Y
Stones / Sludge / Polyps N Y

KIDNEYS

Parenchyma

RT _____ x _____ x _____ cm

Echogenicity	nl	abnl
Size	nl	abnl
Contour	nl	abnl
Calcifications	nl	abnl
Masses (Solid/Cystic)	N	Y

Calyces
Hydronephrosis N Y

LT _____ x _____ x _____ cm

Echogenicity	nl	abnl
Size	nl	abnl
Contour	nl	abnl
Calcifications	nl	abnl
Masses (Solid/Cystic)	N	Y

Hydronephrosis N Y

SPLEEN

Parenchyma

Size	nl	abnl
Calcifications	N	Y

_____ x _____ x _____ cm

ASCITES N Y

PLEURAL EFFUSION N Y (RT / LT)

Comments_____TECH____

AORTA ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN #_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX / INDICATIONS_____

PREVIOUS EXAMS_____

AORTA

CALIBER nl abnl

PROX _____ x _____ x _____ CM

MID _____ x _____ x _____ CM

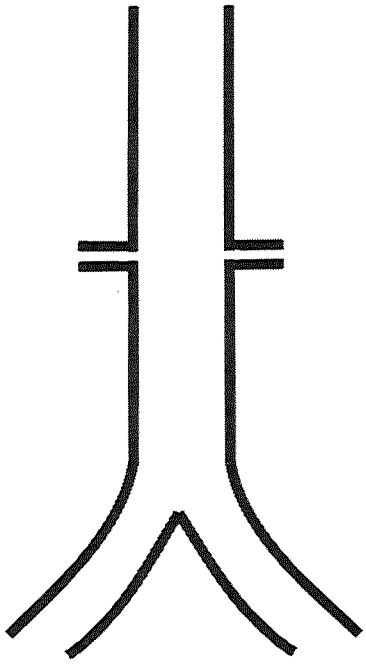
DISTAL _____ x _____ x _____ CM

ANEURYSM Y N

SIZE: TRANS _____ x _____ CM

SAG _____ x _____ CM

INFRARENAL Y N



COMMON ILIACS

CALIBER nl abnl

RT _____ x _____ x _____CM

LT _____ x _____ x _____ CM

Comments_____

_____TECH_____

BREAST ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN #_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

RIGHT BREAST

CYST 1) _____ x _____ x _____cm
2)_____ x _____ x _____cm
3)_____ x _____ x _____cm

COMPLEX 1) _____ x _____ x _____cm
2)_____x _____ x _____cm

SOLID MASS 1) ____x_____x_____cm
2)____x_____x_____cm

DENSE FIBROUS TISSUE_____

LYMPH NODE_____

NO MASSES SEEN_____

LEFT BREAST

CYST 1) _____ x _____ x _____cm
2) _____ x _____ x _____cm
3) _____ x _____ x _____cm

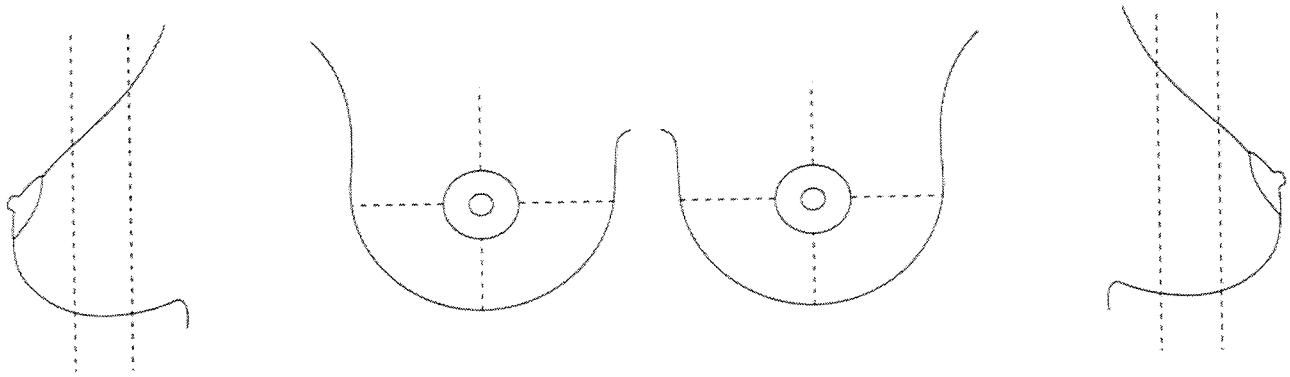
COMPLEX 1)_____ x _____ x _____cm
2)_____ x _____ x _____cm

SOLID MASS 1)____x_____x_____cm
2)____x_____x_____cm

DENSE FIBROUS TISSUE_____

LYMPH NODE_____

NO MASSES SEEN_____



Comments_____
_____TECH_____

RT **LT**

CAROTID DOPPLER ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

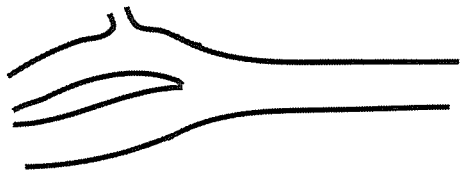
MRN #_____ORDERING PHYSICIAN_____ ER___OP___IP___

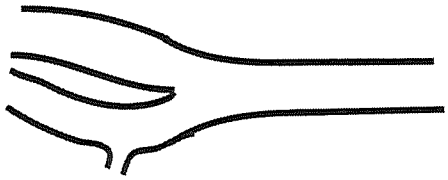
HX / INDICATIONS_____

PREVIOUS EXAMS_____

SYMPTOMS: AMS_____ HYPERTENSION_____ APHASIA_____ VISION CHANGES_____
HYPERLIPIDEMIA_____ WEAKNESS_____ DIABETES_____ HEART HX_____
VERTIGO_____ SMOKER_____ NUMBNESS_____ PRE-OP_____
SYNCOPE_____ PRIOR STROKE_____ TINGLING_____ IMBALANCE_____
CONFUSION_____ DIZZINESS_____ FACIAL DROOP_____ SLURRED SPEECH_____
PRIOR ENDART (RT / LT) YR:_____

	RIGHT	LEFT
SAMPLE LOCATION	**PSV/EDV (CM/SEC)**	**PSV/EDV (CM/SEC)**
CCA	/	/
ICA	/	/
ECA		
VERTEBRAL	ANTE RETRO	ANTE RETRO
ICA/CCA RATIO		





	Primary Parameters		Additional Parameters	
Degree of Stenosis, %	**ICA PSV, cm/sec**	**Plaque Estimate, %***	**ICA/CCA PSV Ratio**	**ICA EDV, cm/sec**
Normal	<180	None	<2.0	<40
<50	<180	<50	<2.0	<40
50-69%**	180–230	>50	2.0–4.0	40–100
>70 but less than near occlusion	>230	>50	>4.0	>100
Near occlusion	High, low, or undetectable	Visible	Variable	Variable
Total occlusion	Undetectable	Visible, no detectable lumen	Not applicable	Not applicable

*Plaque estimate (diameter reduction) with grayscale and color Doppler US.

Comments_____TECH_____

FISTULA TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

DATE OF A/V FISTULA PLACEMENT_____

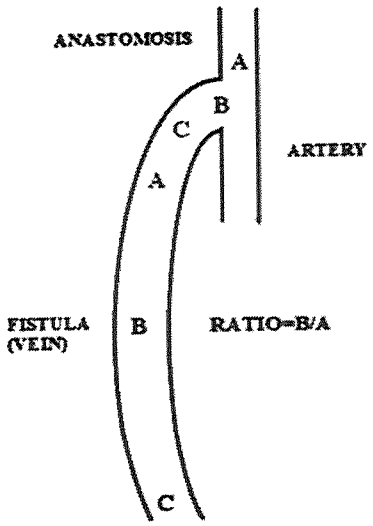
Exam Dates:	/ /	/ /	/ /	/ /

Anastomosis

Arterial PSV	cm/s	cm/s	cm/s	cm/s
Within PSV	cm/s	cm/s	cm/s	cm/s
Fistula PSV	cm/s	cm/s	cm/s	cm/s
Ratio				

Fistula

Peripheral PSV	cm/s	cm/s	cm/s	cm/s
Mid PSV	cm/s	cm/s	cm/s	cm/s
Central PSV	cm/s	cm/s	cm/s	cm/s
Ratio				



Comments_____

_____

_____

_____

_____

_____TECH____

LOWER EXTREMITY ARTERIAL GRAFT/BYPASS EVALUATION TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

EXAM DATES	/ /	/ /	/ /

PROXIMAL ANASTOMOSIS

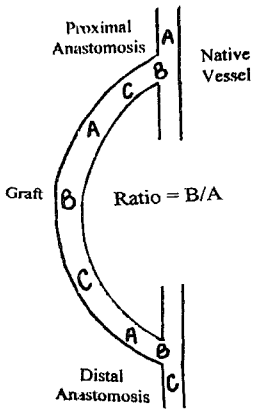
BEFORE PSV	cm/s	cm/s	cm/s
WITHIN PSV	cm/s	cm/s	cm/s
AFTER PSV	cm/s	cm/s	cm/s
RATIO			

GRAFT

PROXIMAL PSV	cm/s	cm/s	cm/s
MID PSV	cm/s	cm/s	cm/s
DISTAL PSV	cm/s	cm/s	cm/s
RATIO			

DISTAL ANASTOMOSIS

BEFORE PSV	cm/s	cm/s	cm/s
WITHIN PSV	cm/s	cm/s	cm/s
AFTER PSV	cm/s	cm/s	cm/s
RATIO			



Comments_____

_____

_____

_____

_____

_____TECH_____

LOWER EXTREMITY VENOUS ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX
INDICATIONS_____

PREVIOUS EXAMS_____

RIGHT LEG

	EIV	CFV	GSV	PROX FV	MID FV	DISTAL FV	POPL
Spontaneous							
Phasic							
Augmentation							
Compressible							
Thrombus							

Comments_____

_____TECH_____

LEFT LEG

	EIV	CFV	GSV	PROX FV	MID FV	DISTAL FV	POPL
Spontaneous							
Phasic							
Augmentation							
Compressible							
Thrombus							

Comments_____

_____TECH_____

LOWER EXTREMITY VENOUS ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX
INDICATIONS_____

PREVIOUS EXAMS_____

RIGHT LEG

	EIV	CFV	GSV	PROX FV	MID FV	DISTAL FV	POPL
Spontaneous	Y	Y	Y	Y	Y	Y	Y
Phasic	Y	Y	Y	Y	Y	Y	Y
Augmentation	Y	Y	Y	Y	Y	Y	Y
Compressible	Y	Y	Y	Y	Y	Y	Y
Thrombus	N	N	N	N	N	N	N

Comments_____ NO THROMBUS VISUALIZED
_____TECH_____

LEFT LEG

	EIV	CFV	GSV	PROX FV	MID FV	DISTAL FV	POPL
Spontaneous	Y	Y	Y	Y	Y	Y	Y
Phasic	Y	Y	Y	Y	Y	Y	Y
Augmentation	Y	Y	Y	Y	Y	Y	Y
Compressible	Y	Y	Y	Y	Y	Y	Y
Thrombus	N	N	N	N	N	N	N

Comments_____ NO THROMBUS VISUALIZED
_____TECH_____

MISCELLANEOUS ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

AREA OF CONCERN:_____

COMMENTS:_____

_____

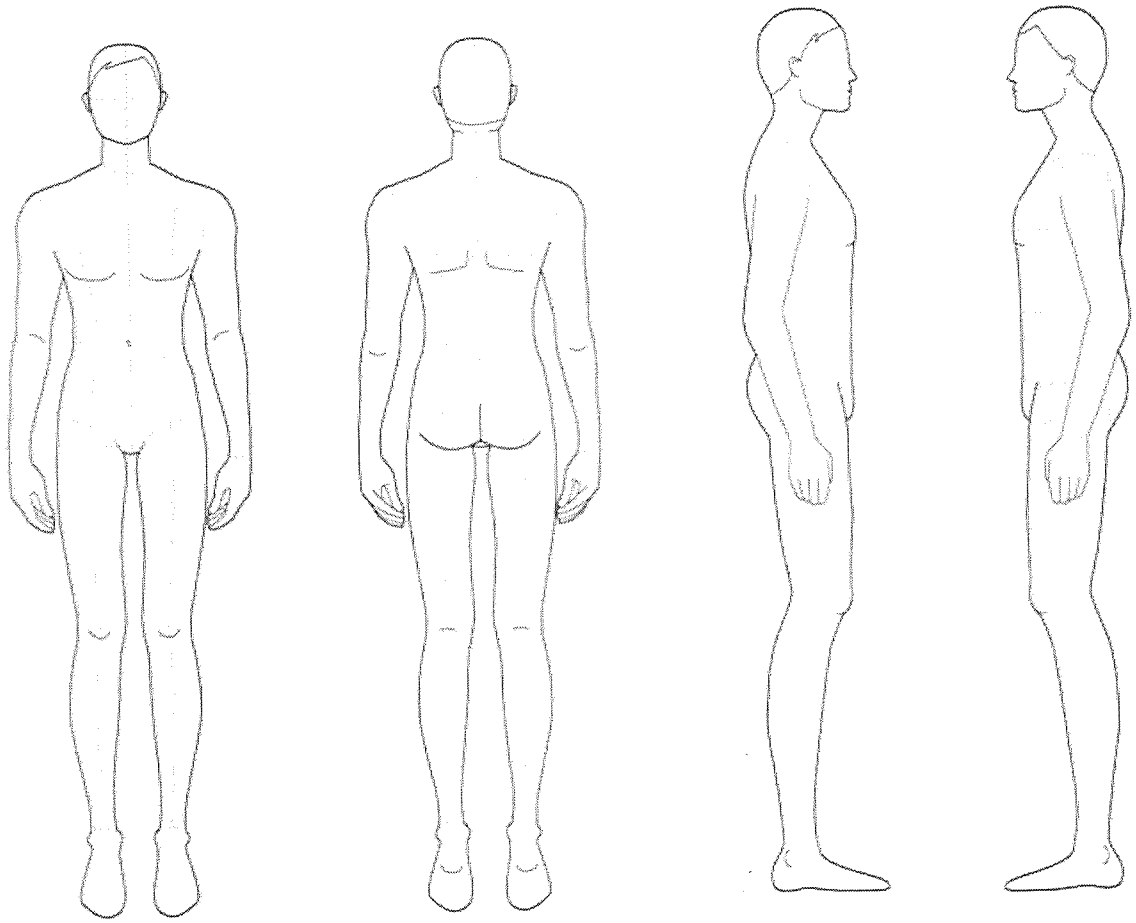
_____

_____

_____

_____

_____TECH_____



FIRST TRIMESTER OB ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____ AGE_____SEX____

MRN #_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX / INDICATIONS_____

PREVIOUS EXAMS_____

G_____ P_____ A_____ TECHNIQUE: TRANSABDOMINAL TRANSVAGINAL

LMP _____/_____/_____ BETA HCG _____

UTERUS _____x_____x_____cm

ENDOMETRIUM_____mm

CUL-DE-SAC FLUID Y N

NABOTHIAN CYST PRESENT Y N

RUQ FLUID: Y N

LUQ FLUID: Y N

GESTATIONAL SAC_____ WKS_____DAYS

CRL_____WKS_____DAYS

FETAL HEART RATE_____ BPM

EDD_____/_____/_____

YOLK SAC PRESENT Y N

SUBCHORIONIC BLEED Y N

RIGHT OVARY

SURGICALLY REMOVED Y N

NORMAL_____x_____x_____CM

ENLARGED_____x_____x_____CM

MASS: SOLID_____x_____x_____CM

CYSTIC_____x_____x_____CM

COMPLEX_____x_____x_____CM

COLOR DOPPLER Y N

LEFT OVARY

SURGICALLY REMOVED Y N

NORMAL_____x_____x_____CM

ENLARGED_____x_____x_____CM

MASS: SOLID_____x_____x_____CM

CYSTIC_____x_____x_____CM

COMPEX_____x_____x_____CM

COLOR DOPPLER Y N

RT ADNEXA_____

LEFT ADNEXA_____

Comments_____

_____TECH_____

OB LIMITED ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____ AGE_____SEX____

MRN #_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX/INDICATIONS_____

PREVIOUS EXAMS_____

G_____ P_____ A_____

Cervix: Length_____cm

Closed Y N

Placenta: Grade: 0 1 2 3

Location: Anterior Posterior Fundal

Cervical os: Clear Low-lying Placenta Previa

Heart Rate: _____bpm

Amniotic Fluid: _____cm Normal Oligohydramnios Polyhydramnios

Fetal Position: Cephalic Transverse Breech Variable

Movement: Present Absent

BPD _____ wks _____ days **HC/AC** _____

HC _____ wks _____ days **FL/AC** _____

AC _____ wks _____ days **FL/BPD** _____

FL _____ wks _____ days **CI** _____

EFW _____ +/- _____ Grams / _____ lb _____oz +/- _____ oz

Predicted Gestational Age:

By LMP: _____ weeks By Initial U/S: _____ weeks By Today's U/S: _____ weeks

_____ days _____ days _____ days

Comments_____TECH_____

BIOPHYSICAL PROFILE TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN #_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX
INDICATIONS_____

PREVIOUS EXAMS_____

G_____ P_____ A_____

	Two Points	Zero Points	Score
Fetal Breathing Movements	At least one episode of at least 30 seconds duration in 30 minutes observation	Absent or no episode of ≥ 30 seconds duration in 30 minutes observation	
Gross Body Movement	At least three discrete body/limb movements in 30 minutes (episodes of active continuous movement is considered a single movement)	Two or fewer episodes of body/limb movements in 30 minutes observation	
Fetal Tone	At least one episode of active extension with return to flexion of fetal limb(s) or trunk; opening and closing of hand is considered normal tone	Either slow extension with partial flexion or movement of limb in full extension of absent fetal tone movement	
Qualitative Amniotic Fluid Volume	At least one pocket of amniotic fluid measuring at least 2cm in two perpendicular planes	Either no amniotic fluid pockets or a pocket <2cm in two perpendicular planes	
		Total:	**/ 8**

Fetal Position:	
Fetal Heart Rate:	bpm
AFI:	cm

Comments_____

_____TECH_____

PELVIC ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX/ INDICATIONS_____

PREVIOUS EXAMS_____

G_____ P_____ A_____ LMP_____ Technique: TRANSABDOMINAL TRANSVAGINAL

UTERUS

SURGICALLY REMOVED Y N

NORMAL _____ x _____ x _____ CM

ENLARGED _____ x _____ x _____ CM

FIBROID _____ x _____ x _____ CM

ENDO_____MM

CUL-DE-SAC FLUID Y N

NABOTHIAN CYST PRESENT Y N

POST MENOPAUSAL Y N

RIGHT OVARY

SURGICALLY REMOVED Y N

NORMAL _____x_____x_____CM

ENLARGED _____x_____x_____CM

MASS: SOLID _____x_____x_____CM

CYSTIC_____x_____x_____CM

COMPLEX _____x_____x_____CM

COLOR DOPPLER Y N

LEFT OVARY

SURGICALLY REMOVED Y N

NORMAL _____x_____x_____CM

ENLARGED_____x_____x_____CM

MASS: SOLID _____x_____x_____CM

CYSTIC_____x_____x_____CM

COMPEX_____x_____x_____CM

COLOR DOPPLER Y N

RT ADNEXA_____

LEFT ADNEXA_____

Comments_____

_____

_____TECH_____

RENAL TRANSPLANT TECHNICAL WORKSHEET

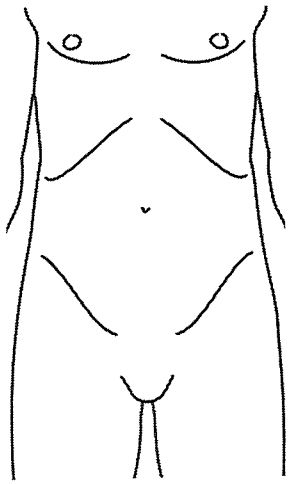
DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

TRANSPLANT PLACED (YR)_____ AGE:_____
LOCATION OF:
TRANSPLANT_____
URETERAL INSERTION_____
RENAL ARTERY ANASTOMOSIS_____



TRANSPLANT KIDNEY

Parenchyma	Size	nl	abnl
	_____ x _____ x _____ CM		
	Echogenicity	nl	abnl
	Cortical thinning	nl	abnl
	Contour	nl	abnl
	Calcifications	N	Y
Masses	Solid	N	Y
	Cystic	N	Y
Calyces	Hydronephrosis	N	Y
Collecting System	Ureter	nl	abnl
Juxtarenal soft Tissues	Fluid Collections	N	Y

Vasculature

	PSV (cm/s)	S/D RATIO
SUPERIOR POLE		
MID POLE		
INFERIOR POLE		

RENAL ARTERY ANASTOMOSIS	PSV (cm/s)
ABOVE	
WITHIN	
DISTAL	

TECH_____

RENAL ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX INDICATIONS_____

PREVIOUS EXAMS_____

RT KIDNEY

Parenchyma	Size	nl	abnl	
	_____ x _____ x _____ CM			
	Echogenicity	nl	abnl	
	Cortical thinning	nl	abnl	
	Contour	nl	abnl	
	Calcifications	N	Y	
Masses	Solid	N	Y	
	Cystic	N	Y	_____ x _____ x _____ CM
				_____ x _____ x _____ CM
				_____ x _____ x _____ CM
Calyces	Hydronephrosis	N	Y	

LT KIDNEY

Parenchyma	Size	nl	abnl	
	_____ x _____ x _____ CM			
	Echogenicity	nl	abnl	
	Cortical thinning	nl	abnl	
	Contour	nl	abnl	
	Calcifications	N	Y	
Masses	Solid	N	Y	
	Cystic	N	Y	_____ x _____ x _____ CM
				_____ x _____ x _____ CM
				_____ x _____ x _____ CM
Calyces	Hydronephrosis	N	Y	

URINARY BLADDER

	Foley	N	Y
	Wall thickness	nl	abnl
	Masses/Stones	N	Y
Ureteral Jets	Rt jet visualized	N	Y
	Lt jet visualized	N	Y

Comments_____TECH____

RIGHT UPPER QUADRANT ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX INDICATIONS_____

PREVIOUS EXAMS_____

PANCREAS

Parenchyma	Echogenicity	nl	abnl
	Size	nl	abnl
	Duct	nl	abnl
	Masses	N	Y
	Calcifications	N	Y

LIVER

Parenchyma	Echogenicity	nl	abnl	
	SIZE _____ cm	nl	abnl	
	Masses (Solid/Cystic)	N	Y	_____ x _____ x _____ cm
	Calcifications	N	Y	

Vascular	Portal vein	nl	abnl	Hepatic Artery	nl	abnl
	Splenic Vein	nl	abnl	Hepatic veins	nl	abnl
	IVC	nl	abnl			

Bile Ducts	Extrahepatic	nl	abnl
	Intrahepatic	nl	abnl
	CBD _____ mm		

GALLBLADDER

Morphology	Wall_____mm			Surgically removed	N	Y
	Length _____cm			Pericholecystic fluid	N	Y
	Murphy's sign	Neg	Pos	Stones / Sludge / Polyps	N	Y

RIGHT KIDNEY

Parenchyma	Echogenicity	nl	abnl	
	Size	nl	abnl	_____ x _____ x _____cm
	Contour	nl	abnl	
	Calcifications	nl	abnl	
	Masses (Solid/Cystic)	N	Y	
Calyces	Hydronephrosis	N	Y	

ASCITES N Y

PLEURAL EFFUSION N Y

Comments_____

_____TECH_____

SAPHENOUS VEIN MAPPING TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX
INDICATIONS_____

PREVIOUS EXAMS_____

RT GREATER SAPHENOUS VEIN

JUNCTION _____MM

MID THIGH _____MM

ABOVE KNEE _____MM

BELOW KNEE _____MM

MID CALF _____MM

ANKLE _____MM

LT GREATER SAPHENOUS VEIN

JUNCTION _____MM

MID THIGH _____MM

ABOVE KNEE _____MM

BELOW KNEE _____MM

MID CALF _____MM

ANKLE _____MM

Comments_____

_____

_____TECH_____

STENT EVALUATION TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

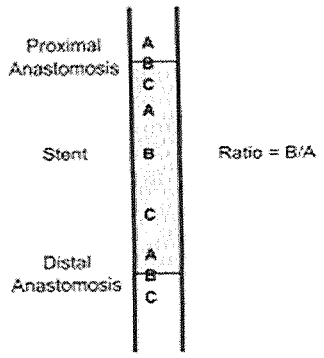
MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

AREA OF SCANNING:_____

EXAM DATES	/ /	/ /	/ /
PROXIMAL ANASTOMOSIS			
BEFORE PSV	cm/s	cm/s	cm/s
WITHIN PSV	cm/s	cm/s	cm/s
AFTER PSV	cm/s	cm/s	cm/s
RATIO			
STENT			
PROXIMAL PSV	cm/s	cm/s	cm/s
MID PSV	cm/s	cm/s	cm/s
DISTAL PSV	cm/s	cm/s	cm/s
RATIO			
DISTAL ANASTOMOSIS			
BEFORE PSV	cm/s	cm/s	cm/s
WITHIN PSV	cm/s	cm/s	cm/s
AFTER PSV	cm/s	cm/s	cm/s
RATIO			



Comments_____

_____

_____

_____

_____TECH____

TESTICULAR ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

RT TESTIS

SURGICALLY REMOVED Y N

NORMAL_____x_____x_____CM

ENLARGED_____x_____x_____CM

MASS: SOLID_____x_____x_____CM
CYSTIC____x_____x_____CM
COMPLEX___x____x_____CM

HYDROCELE Y N

DOPPLER FLOW:

ARTERIAL: Y N
VENOUS: Y N

LT TESTIS

SURGICALLY REMOVED Y N

NORMAL_____x_____x_____CM

ENLARGED_____x_____x_____CM

MASS: SOLID _____x_____x_____CM
CYSTIC_____x_____x_____CM
COMPLEX____x____x_____CM

HYDROCELE Y N

ARTERIAL: Y N
VENOUS: Y N

RIGHT EPIDIDYMIS

NORMAL_____x_____x_____CM
ENLARGED_____x_____x_____CM
MASS: SOLID_____x_____x_____CM
CYSTIC____x_____x_____CM
COMPLEX___x____x_____CM

VARICOCELE Y N

INGUINAL CANAL_____

LT EPIDIDYMIS

NORMAL_____x_____x_____CM
ENLARGED_____x_____x_____CM
MASS: SOLID _____x_____x_____CM
CYSTIC_____x_____x_____CM
COMPLEX____x____x_____CM

VARICOCELE Y N

INGUINAL CANAL_____

Comments_____
_____TECH_____

THYROID ULTRASOUND TECHNICAL WORKSHEET

DATE_____PATIENT_____AGE_____SEX_____

MRN#_____ORDERING PHYSICIAN_____ ER_____OP_____IP____

HX INDICATIONS_____

PREVIOUS EXAMS_____

RT LOBE

SURGICALLY REMOVED N Y

NORMAL_____x_____x_____CM

ENLARGED____x_____x_____CM

NODULE: SOLID_____CM
_____CM
_____CM

CYSTIC_____CM
_____CM
_____CM

COMPLEX_____CM
_____CM
_____CM

LT LOBE

SURGICALLY REMOVED N Y

NORMAL_____x_____x_____CM

ENLARGED_____x_____x_____CM

NODULE: SOLID_____CM
_____CM
_____CM

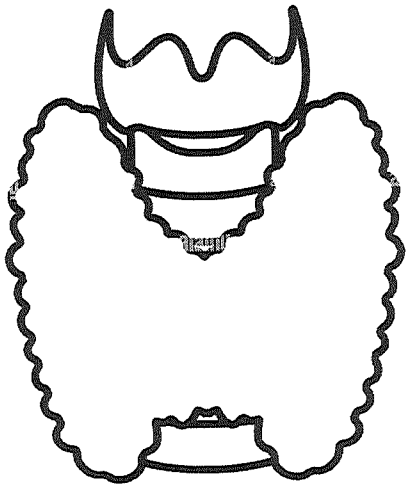
CYSTIC_____CM
_____CM
_____CM

COMPLEX_____CM
_____CM
_____CM

STHMUS

SIZE_____CM

MASS: SOLID _____CM
CYSTIC_____CM
COMPLEX_____CM



Comments_____TECH_____

UPPER EXTREMITY VENOUS ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX INDICATIONS_____

PREVIOUS EXAMS_____

RIGHT ARM

	IJV	SUBCLAVIAN	AXILLARY	BRACHIAL	BASILIC	CEPHALIC
Sniff						
Augmentation						
Phasic						
Compressible						
Thrombus						

Comments_____

_____TECH_____

LEFT ARM

	IJV	SUBCLAVIAN	AXILLARY	BRACHIAL	BASILIC	CEPHALIC
Sniff						
Augmentation						
Phasic						
Compressible						
Thrombus						

Comments_____

_____TECH_____

UPPER EXTREMITY VENOUS ULTRASOUND TECHNICAL WORKSHEET

DATE_____ PATIENT_____ AGE_____SEX____

MRN#_____ORDERING PHYSICIAN_____ ER___OP___IP___

HX INDICATIONS_____

PREVIOUS EXAMS_____

RIGHT ARM

	IJV	SUBCLAVIAN	AXILLARY	BRACHIAL	BASILIC	CEPHALIC
Sniff	Y	Y	Y	Y	Y	Y
Augmentation	Y	Y	Y	Y	Y	Y
Phasic	Y	Y	Y	Y	Y	Y
Compressible	Y	Y	Y	Y	Y	Y
Thrombus	N	N	N	N	N	N

Comments NO THROMBUS VISUALIZED

_____TECH_____

LEFT ARM

	IJV	SUBCLAVIAN	AXILLARY	BRACHIAL	BASILIC	CEPHALIC
Sniff	Y	Y	Y	Y	Y	Y
Augmentation	Y	Y	Y	Y	Y	Y
Phasic	Y	Y	Y	Y	Y	Y
Compressible	Y	Y	Y	Y	Y	Y
Thrombus	N	N	N	N	N	N

Comments NO THROMBUS VISUALIZED

_____TECH_____