McLaren

CARO REGION

ULTRASOUND THYROID EVALUATION

Patient Name :_____ **DATE:** _____

DOB :_____ **MR# :**_____ **REFERRING PHYSCIAN:** _____

Indication for Exam:

_____Difficulty Swallowing

_____Nervousness

_____Fatigue

_____Palpable Mass

_____Excessive Sweating

_____Hair Loss

_____Weight Gain/Loss

_____Follow Up

_____

Previous Exam

Ultrasound:_____

Nuclear Medicine:_____

Biopsy:

☐ Right :_____

☐ Left:_____

Thyroid Meds:

☐ **Yes:**_____

☐ **No**

Right = _____x_____x_____cm Height_____

Left = _____x_____x_____cm Weight_____

Isthmus =_____

Comments:_____

_____

_____

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Sonographer :_____ **Date:** _____

FORM: US 12

NEW: 10-4-19