CARO REGION

Renal Artery Duplex

Name: ______________________________ DOB: ______________

MR#: ______________ Referring Physician: ______________________________

Diagnosis: ____

Rt Kidney: _____ x _____ x _____cm ______________________________

____

Lt Kidney: _____ x _____x _____cm ______________________________

____

	RT MRA	Acc. Time
PROX		
MID		
DIST		

	LT MRA	Acc. Time
PROX		
MID		
DIST		

Velocity:

RT RAR:	LT RAR:

Rt Arcuates: Lt Arcuates:

	Velocities	Acc. Time	RI	Velocities	Acc. Time	RI
SUP						
MID						
INF						

Technologist: ______________________________ Date: ______________

FORM: US 19
NEW: 9-9-2020