McLaren

CARO REGION

ULTRASOUND SCROTAL EVALUATION

Patient Name:_____ **DATE:** _____

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

Indication for Exam:_____

_____

_____Pain

_____Swelling

_____Discoloration

_____Trauma

_____Palpable Mass

_____Hx. Infections

_____Fever

_____Follow Up

Previous Exam

Nuclear Medicine:_____

Ultrasound:_____

Surgery:

☐ Right:_____

☐ Left:_____

Right	**Left**
_____x_____x_____cm	_____x_____x_____cm
Color Flow Seen: Yes☐ No☐	**Color Flow Seen:** Yes ☐ No☐
Epi:_____	**Epi:**_____
_____	_____
RI:_____ **PSV:** _____cm/s	**RI:** _____ **PSV:** _____cm/s

Comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Sonographer :_____ **Date:** _____

FORM: US 13

NEW: 10-4-19