

RENAL / BLADDER ULTRASOUND

Patient Name

DOB

MRN

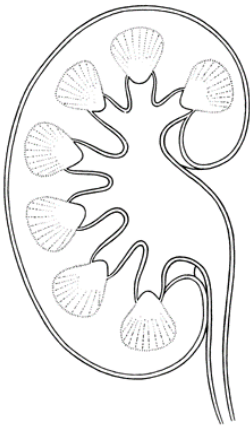
Tech _____

History: ☐ HTN ☐ Diabetes ☐ Nephrolithiasis ☐ Renal Failure ☐ Acute ☐ Chronic

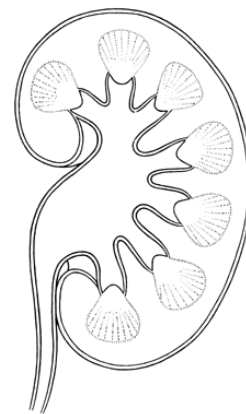
Surgical History: _____

Indication: ☐ Flank Pain ☐ R ☐ L ☐ Hematuria ☐ Proteinuria ☐ Frequent Urination

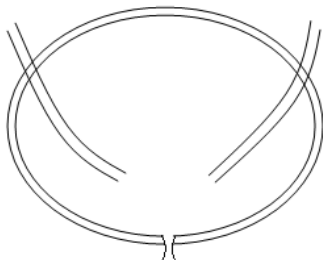
☐ Other _____



RIGHT KIDNEY _____ x _____ x _____ cm



LEFT KIDNEY _____ x _____ x _____ cm



BLADDER AP Wall Thickness _____ mm

COMMENTS
