RENAL / BLADDER ULTRASOUND

Patient Name

DOB

MRN

Date _____

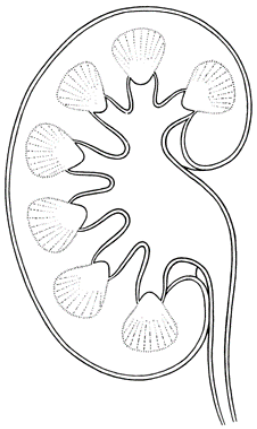
Tech _____

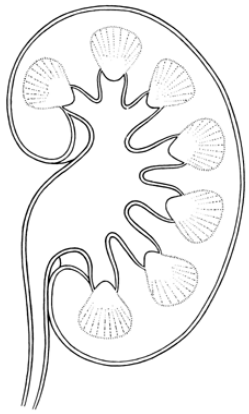
History: ☐ HTN ☐ Diabetes ☐ Nephrolithiasis ☐ Renal Failure ☐ Acute ☐ Chronic

Surgical History: _____

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

☐ Other _____





RIGHT KIDNEY _____ x _____ x _____ cm

_____

_____

_____

_____

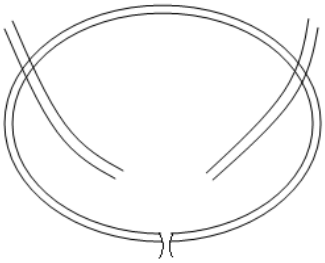
LEFT KIDNEY _____ x _____ x _____ cm

_____

_____

_____

_____



BLADDER AP Wall Thickness _____ mm

_____

_____

_____

_____

COMMENTS

_____

_____

_____