



General Ultrasound

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Kansas City, MO 64111

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www.globaldxi.com

Name: _____ Date: _____ Sonographer: _____
DOB: _____ Age: _____ Location: _____ Ordering Physician: _____
Sex: _____ Ht: _____ Wt: _____

Indicatons:

Impression:

Technique:

Description of Findings:

(Electronically Signed)