



Scrotal Ultrasound (76870)

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

Indicatons:

Impression:

Technique:

Observations & Measurements

	<u>Measurements</u>	AP	Transverse	Craniocaudad
Right Testis	Right Testis :			mm
Right Epididymis:	Right Epididymis			mm
Right Scrotum				
Left Testis	Left Testis:			mm
Left Epididymis	Left Epididymis			mm
Left Scrotum	Nodule / Mass			mm
				mm

Description of Findings:

(Electronically Signed)