UNITED IMAGING
CONSULTANTS

Abdominal Aortic Ultrasound/Doppler

Exam Date		Room #	
Tech Name		Tech Phone	
Ordering MD Name		Ordering MD Phone	
Nurse Name		Nurse Phone	

Patient Name	
DOB	
MR#	
(Sticker OR Fill-out)	

Indication/History: ☐ Screening ☐ Known aneurysm ☐ HTN ☐ Smoking hx ☐ +Fam hx ☐ Claudication

Specify: _____ Prior Exam Date:_____

Note to Tech: Must obtain longitudinal and transverse gray scale imaging of prox/mid/distal aorta AND color and/or spectral doppler waveforms of the distal aorta at a minimum.

Proximal _____x_____ cm. (AP x ML)

Mid _____x_____ cm. Prior aneurysm measurement (if positive): _____ cm.

Distal _____x_____ cm. Aorta PSV: _____ cm/s.

Right CIA: _____ cm. PSV: _____ cm/s. Left CIA: _____ cm. PSV: _____ cm/s.

Incidental findings: _____

_____

IMPRESSION: ☐ Aneurysm ☐ Stenosis ☐ Atherosclerotic changes

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