

**Renal Doppler Ultrasound**

Exam Date		Room #		Patient Name	
Tech Name		Tech Phone		DOB	
Ordering MD Name		Ordering MD Phone		MR#	
Nurse Name		Nurse Phone		(Sticker OR Fill-out)	

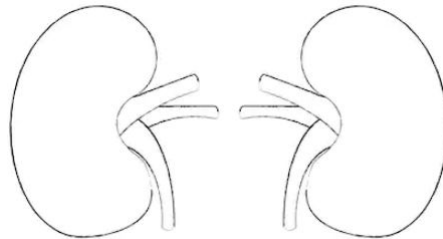
**Indication/History:**  HTN  RV Thrombosis  CKD  AKI  ↑Cr  Mass  Renal Transplant  
**Specify:** \_\_\_\_\_

<b>Aorta PSV at RA origins (cm/s):</b>		<input type="checkbox"/> Plaque <input type="checkbox"/> Stenosis <input type="checkbox"/> Aneurysm size _____cm		<60%
<b>Right:</b> <input type="checkbox"/> Single <input type="checkbox"/> Multiple #		<b>Left:</b> <input type="checkbox"/> Single <input type="checkbox"/> Multiple #		
PSV Prox / RI		PSV Prox / RI		<180
PSV Mid / RI		PSV Mid / RI		<0.7
PSV Distal / RI		PSV Distal / RI		
Greatest RAR		Greatest RAR		<3.5
Intrarenal RI: <input type="checkbox"/> Parvus tardus		Intrarenal RI: <input type="checkbox"/> Parvus tardus		<0.8
<b>RRV:</b> <input type="checkbox"/> Patent <input type="checkbox"/> Thrombosed		<b>LRV:</b> <input type="checkbox"/> Patent <input type="checkbox"/> Thrombosed		
<b>IVC:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Thrombus <input type="checkbox"/> Duplicated				

**Right Kidney:** Size \_\_\_\_x\_\_\_\_x\_\_\_\_ cm      **Left Kidney:** Size \_\_\_\_x\_\_\_\_x\_\_\_\_ cm

- |  |                                    |  |  |                                    |  |
|--|------------------------------------|--|--|------------------------------------|--|
| <input type="checkbox"/> Normal              | <input type="checkbox"/> Echogenic | <input type="checkbox"/> Cortical thinning | <input type="checkbox"/> Normal              | <input type="checkbox"/> Echogenic | <input type="checkbox"/> Cortical thinning |
| <input type="checkbox"/> Hydronephrosis mild | <input type="checkbox"/> moderate  | <input type="checkbox"/> severe            | <input type="checkbox"/> Hydronephrosis mild | <input type="checkbox"/> moderate  | <input type="checkbox"/> severe            |
| <input type="checkbox"/> Stones              |                                    |  | <input type="checkbox"/> Stones              |                                    |  |

Indicate lesions as cystic ○, complicated ⊙, solid ●, or stone ◆, with sizes in mm.



**Bladder:**  Normal  Wall thickening  Foley  R jet  L jet  Other \_\_\_\_\_

**IMPRESSION/SUMMARY:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_