UNITED IMAGING
CONSULTANTS

Scrotal Ultrasound

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)	

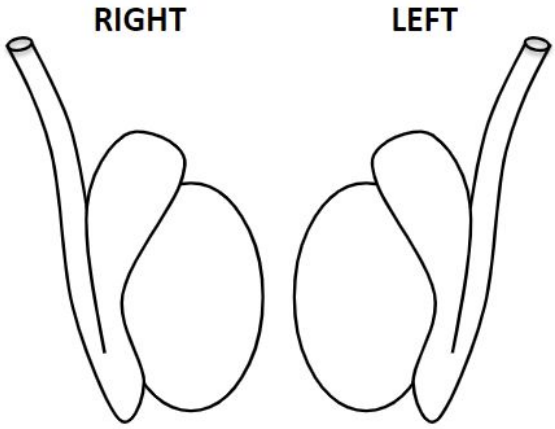
Indication/History: ☐ Pain R / L ☐ Mass R / L ☐ Swelling R / L ☐ Trauma ☐ Infertility

Specify: _____

Right Testis: Size_____x_____x_____ cm
Texture: ☐ Homogeneous ☐ Hetero
Flow: ☐ WNL ☐ Increased ☐ Decreased
Epididymis: ☐ WNL ☐ Enlarged ☐ Hyperemic
Varicocele: ☐ None ☐ Size_____ mm
Hydrocele: ☐ None ☐ Simple ☐ Complicated
Scrotum: ☐ WNL ☐ Thickened ☐ Collection

Left Testis: Size_____x_____x_____ cm
Texture: ☐ Homogeneous ☐ Hetero
Flow: ☐ WNL ☐ Increased ☐ Decreased
Epididymis: ☐ WNL ☐ Enlarged ☐ Hyperemic
Varicocele: ☐ None ☐ Size_____ mm
Hydrocele: ☐ None ☐ Simple ☐ Complicated
Scrotum: ☐ WNL ☐ Thickened ☐ Collection

Indicate lesions with sizes in mm.



Hernia: ☐ None ☐ _____

Lymph nodes: ☐ None ☐ _____

IMPRESSION/SUMMARY:_____

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