Ultrasound Pediatric Scrotum with Doppler Worksheet

Patient Name:_____ DOB: _____________

Site: _____ Tech/ext: _____ Date: ____________

ACC# _____ Height (cm): _____ Age: _____

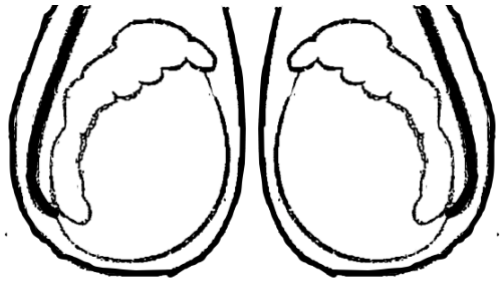
MRN#_____ Weight (kg): _____ BMI: _____

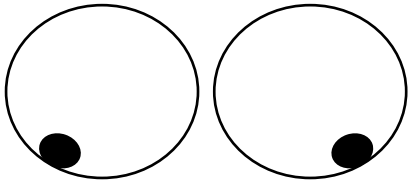
Ref Physician: _____ History (What, Where, When):

Indications: _____

_____

	Yes	No	Measurements	Volume)
Right Testis ☐ **Symptomatic?**			Length _____ (cm) Height_____ (cm) Width _____ (cm)	_____ **(cm^3)**
Color Flow				
Pulsed Doppler				
Right Epi Head			Length _____ (cm) Height_____ (cm) Width _____ (cm)	
Color Flow				
Comments				
Left Testis ☐ **Symptomatic?**			Length _____ (cm) Height_____ (cm) Width _____ (cm)	_____ **(cm^3)**
Color Flow				
Pulsed Doppler				
Left Epi Head			Length _____ (cm) Height_____ (cm) Width _____ (cm)	
Color Flow				
Comments				





Name of Radiologist Consulted:

_____

Did Radiologist Scan? Y or N

☐ Additional Worksheet Used

(Revised. 3/23/23)