

Ultrasound Preliminary Report Form

ULTRASOUND PRELIMINARY REPORT

Date/Time: _____

Patient Name: _____

Hospital #: _____

History: _____

Exam: _____

Findings: _____

Diagnosis: _____

Recommendations: _____

Physician Notified: _____ Ext. _____ Date/Time: _____

Resident Signature: _____ Date/Time: _____

Attending: _____ Date/Time: _____

Adequate correlation ___ Minor discrepancy ___ Major discrepancy ___

Notes: _____
