

Ultrasound Test Report

Patient Information:

- **Name:** [Patient Full Name]
- **Age:** [Patient Age]
- **Gender:** [Male/Female/Other]
- **Patient ID:** [Patient ID or Registration No.]
- **Date of Birth:** [Patient DOB]
- **Report Date:** [Date of Report]
- **Doctor:** [Doctor's Name & Specialty]

Test Information:

- **Test Name:** Ultrasound (Specify type: Abdominal, Pelvic, Renal, etc.)
- **Test Date:** [Date of Test]
- **Lab/Center:** [Lab Name or Center Address]
- **Technician Name:** [Technician Name]
- **Sample ID:** [Sample Identification Number]

Ultrasound Findings:

Organ/System	Findings	Normal Range/Comments
Liver	[E.g., Normal size, No lesions]	Normal
Gallbladder	[E.g., No gallstones, Normal wall]	Normal
Kidneys	[E.g., Left kidney normal, Right hydronephrosis]	Normal/Size and echogenicity
Pancreas	[E.g., Normal echogenicity, No masses]	Normal
Spleen	[E.g., Normal size, No lesions]	Normal
Aorta	[E.g., No aneurysm, Normal diameter]	Normal
Urinary Bladder	[E.g., Partially filled, No stones]	Normal

Uterus (if applicable)	[E.g., Normal size, Endometrium thickness]	Normal
Ovaries (if applicable)	[E.g., Normal appearance, No cysts]	Normal
Prostate (if applicable)	[E.g., Normal size, No nodules]	Normal

Impression:

- **Overall Findings:**

[E.g., "Normal abdominal ultrasound with no significant abnormalities detected."]

[E.g., "Right hydronephrosis observed, recommend urology referral."]

[E.g., "Presence of gallstones, follow-up required."]

Recommendations:

- **Follow-Up Tests:**

[E.g., "Consider CT scan for further evaluation of kidneys," "Follow-up ultrasound in 3 months."]

- **Additional Consultations:**

[E.g., "Referral to gastroenterologist for gallstones," "Urology consultation recommended."]

- **Treatment/Management:**

[E.g., "Monitoring of gallstones," "Start medication for hydronephrosis."]

Technician Signature: [Signature]

Doctor's Signature: [Signature]

Date: [Report Date]