

TESTES ULTRASOUND WORKSHEET

Patient I.D.	Sonographer
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Scan Quality _____

Clinical Indication / Relevant Surgery

<p>Right Testis</p> <p>_____x_____x_____mm</p> <p>Vascularity</p> <p>Hydrocoele Y / N Varicocele Y / N</p>	<p>Left Testis</p> <p>_____x_____x_____mm</p> <p>Vascularity</p> <p>Hydrocoele Y / N Varicocele Y / N</p>
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<p>Right Epididymis</p> <p>Vascularity</p>	<p>Left Epididymis</p> <p>Vascularity</p>
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Scrotal Wall

Other