

ULTRASOUND OF THE THYROID

Date of service:	
Patient Name:	MR#:
Age:	Gender:
Referring Physician:	
Any nodules? YES NO If YES, where?	
Previous Surgeries:	
Previous Nuclear Exam Performed: YES NO	
If YES, where?	
Is thyroid medication being taken at this time? YES NO	
If Yes, what medication?	
Technologist:	

