DCA DONOR CARE ASSOCIATION
Organspende Interkantonal

Abdominal

Abdominal echography or CT Scan Date and Time: _____

Liver Size (mediaclaviculär) _____
Steatosis □ yes □ no _____ %
Patent portal vein □ yes □ no
Focal lesions: _____
Splenomegaly □ yes □ no
Pancreas: _____

Kidneys	**Right**	**Left**
Size (two dimension)	_____ x _____ mm	_____ x _____ mm
Suspicious tumor-like lesion present	□ yes □ no	□ yes □ no
Number of renal arteries	_____	_____
Polar arteries (if yes please specify)	□ yes □ no _____	□ yes □ no _____
	_____	_____
Calcified plaques ostium	□ yes □ no	□ yes □ no
Calcified plaques trunk	□ yes □ no	□ yes □ no
Renal artery, ectopic iliac origin	□ yes □ no	□ yes □ no
Retro-aortic left renal vein		□ yes □ no
Kidney stones	□ yes □ no	□ yes □ no
Cysts	□ yes □ no	□ yes □ no
Number	_____	_____
Size of largest cyst	_____ mm	_____ mm
Pyelocalyceal dilatation	□ yes □ no	□ yes □ no
Arterial thrombosis	□ yes □ no	□ yes □ no
Abscess or infarct area(s)	□ yes □ no	□ yes □ no
Irregular kidney outline	□ yes □ no	□ yes □ no
Cortical thinning < 10 mm	□ yes □ no	□ yes □ no

Comment: _____

_____

_____

Specialist: _____

WICHTIG: Diese Angaben ersetzten keinen zeitnahen schriftlichen Befund in der Patientenakte.

Bei Rückfragen gerne unter 044 255 22 22 melden