X-RAY ASSOCIATES

NOT A REPORT SONOGRAPHER'S COMMENTS ONLY

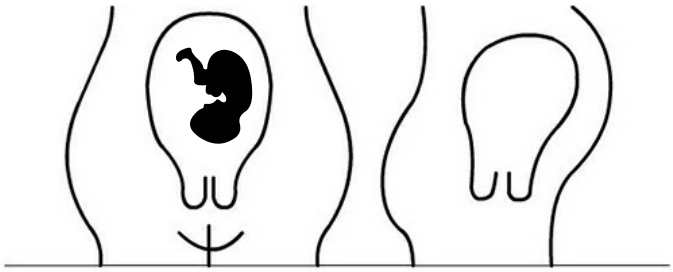
Pt. Name: **Date of Exam:** **Referring:**
Pt. ID:
DOB
Sex:

THIRD TRIMESTER OBSTETRICS

☐ **Patient Identity and Referring Physician Confirmed**

PREV ☐ Yes ☐ No ☐ MH ☐ SRHC ☐ OTHER

Clinical History:



GESTATIONAL AGE: Based on

☐ LMP
☐ EDC
☐ By 1st US
☐ By Latest US
☐ Previous C-Section

CERVICAL LENGTH cm **Presentation** ☐ Fetal Movement FETAL HEART RATE _____ bpm ☐ FETAL HEART RATE ABSENT	**PLACENTA** **PREVIA** PLACENTA TO INTERNAL OS DISTANCE _____ cm	**AMNIOTIC FLUID** **SDP** AP _____ cm W _____ cm **AFV**

FETAL BIOMETRY

BPD	CM	WEEKS	DAYS
HC	CM	WEEKS	DAYS
AC	CM	WEEKS	DAYS
FL	CM	WEEKS	DAYS

AVERAGE WEEKS DAYS
EFW grams
Percentile %
EDC. by current study

CORD DOPPLER RATIOS:
AVERAGE:

Comments:
Fetal Anatomical exam not preformed.

GENDER REQUESTED ☐ **Y** ☐ **N** **Appears** ☐ **Male** ☐ **Female** ☐ **Not Seen**

Transvaginal ☐ Yes ☐ No ☐ Verbal Consent Obtained
Translabial ☐ Yes ☐ No
Probe Identifier _____

_____ DMS