X-RAY ASSOCIATES

NOT A REPORT - SONOGRAPHER'S COMMENTS ONLY

Pt. Name:
Pt. ID:
DOB
Sex:

Date of Exam:
Referring:

FIRST TRIMESTER OBSTETRICS

☐ **Patient Identity and Referring Physician Confirmed**

PREVIOUS Y☐ N☐ MH☐ SRHC☐ OTHER☐
IPS☐

Clinical History:

TRANSVAGINAL SCAN Y☐ N☐
VERBAL CONSENT OBTAINED☐
PATIENT REFUSED☐
Probe Identifier _____

GESTATIONAL AGE: Based on

☐ LMP _____ GA WEEKS DAYS
☐ EDC _____
☐ By 1st US _____
☐ Prev C-section

Intrauterine Sac
Yolk Sac YS cm
Embryo
Fetal Movement
FETAL HEART RATE _____ bpm
Fetal Heart Rate

FETAL BIOMETRY

MSD	CM	WEEKS	DAYS
CRL	CM	WEEKS	DAYS
BPD	CM	WEEKS	DAYS

AVERAGE AGE: WEEKS DAYS
EDC by current study:

PLACENTA

NORMAL STRUCTURES
Choroid Plexus
Stomach
Bladder
Upper Extremities
Lower Extremities

UTERUS

Sub-Chorionic Hemorrhage cm
Location:

RT OVARY x x cm cc)

LT OVARY x x cm cc)

ADENEXA
Free Fluid ☐ Y ☐ N

NUCHAL TRANSLUCENCY mm Tech Code _____
Nasal Bones

COMMENTS:

_____ DMS