UNITED IMAGING
CONSULTANTS

ULTRASOUND FEMALE PELVIS

Exam Date		Room #	
Tech Name		Tech Phone	
Ordering MD Name		Ordering MD Phone	
Nurse Name		Nurse Phone	

Patient Name	
DOB	
MR#	
(Sticker OR Fill-out)	

INDICATION: ☐ Pelvic pain R / L ☐ Mass ☐ Abnormal bleeding ☐Other: _____
☐ Follow up _____

METHOD: ☐ Complete ☐ Transabdominal ☐ Transvaginal

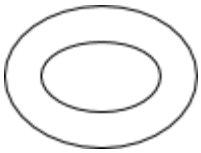
UTERUS: ☐ Ante ☐ Retro ☐ Neutral ☐ Hysterectomy

Size: _____x _____x _____ cm

Endometrium: _____mm ☐ IUD

Mass(es): (Indicate site on diagram)
1)
2)
3)

TRANSVERSE:



LONGITUDINAL:

RIGHT OVARY: _____x _____x _____ cm Masses (Size and description):

Arterial waveform: Y N
Venous waveform: Y N

LEFT OVARY: _____x _____x _____ cm Masses:

Arterial waveform: Y N
Venous waveform: Y N

BLADDER: ☐ Normal ☐ Decompressed/Foley ☐ Mass ☐ Other: _____

Free Fluid: ☐ Small ☐ Moderate ☐ Large ☐ Complex: _____

SUMMARY:_____

_____

_____

_____