UNITED IMAGING
CONSULTANTS

FIRST TRIMESTER OBSTETRIC ULTRASOUND

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: _____

☐ Dating pregnancy / Assess viability
☐ Spotting or bleeding
☐ Pain or cramping
☐ Previous ectopic pregnancy

G_____ P_____
LMP age: _____
EDC:_____ by LMP/ Prior SONO
Comparison US: _____

UTERUS:

Size: _____x _____x _____ cm

Endometrium: _____mm

Masses:

Cervix Length:

R OVARY:_____x _____x _____ cm
Arterial and venous waveform: Y N

Masses:

L OVARY:_____x _____x _____ cm
Arterial and Venous waveform: Y N

Masses:

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

Intrauterine Gestation: Visualized / Not Visualized
Fetal Number ☐ Singleton ☐ Twin ☐ _____
(If >1, indicate #chorion, #amnion, attach separate sheet for each)

Gestational Sac: ☐ Regular ☐ Irregular

MSD: _____ cm GA: ____ weeks ____ days

Yolk Sac: V NV

Fetal pole: V NV

CRL: _____ cm GA: ____ weeks ____ days
Heart Rate: _____ bpm

Placenta Localization: ☐ Ant ☐ Post ☐ _____
Subchorionic Hemorrhage: N Y
Placental Abruption: N Y
Amniotic Fluid: Normal Low High
Other:

SUMMARY: EGA by US: ____ weeks ____ days. ☐ Normal ☐ _____

COMMENTS:_____

_____

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