LIMITED OB ULTRASOUND

☐ Transabdominal ☐ **Transvaginal**

Date _____ Tech _____

G ____ P ____ A ____ E ____ LMP _____

Patient sticker

Prior OB US (this pregnancy): ☐ **Yes** ☐ **No** ☐ **on PACS** **EDD** _____
☐ **at Dr's office**

Indication _____

Indication ☐ Presentation ☐ Placenta ☐ AFI ☐ FHR (Viability)

Fetal Number: 1 2 3 4 **Presentation:** ☐ Cephalic ☐ Breech: ☐ Footling ☐ Frank **Lie:** ☐ Longitudinal ☐ Transverse ☐ Oblique **Head** : ☐ Right ☐ Left	**PLACENTA** **Location:** ☐ Anterior ☐ Posterior ☐ Fundal ☐ Lateral R L	**AFI** Total: _____ **mm**
Cervical Length _____ **cm** TA / TV ☐ Closed ☐ funneling ☐ NWS _____ _____ FHR _____BPM	**Position:** ☐ Normal/above os ☐ low lying ____cm from internal os ☐ Previa	**Max Vertical** %tile range (mm) **Pocket:** _____ **mm** Percentile range: _____ **th** _____ 5th _____ 10th _____ **50th** _____ 90th _____ 95th Normal ☐ Oligo- ☐ Poly- ☐

If no previous US - LMP age _____ w _____ d

EDD by 1st US _____ _____ w_____ d done on _____

Uterus _____

Ovaries_____

Cul-de-sac_____

Comments

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NOT A MEDICAL DOCUMENT