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

Cervical Length _____**cm** TA / TV

□ Closed □ funneling □ NWS

_____

_____

FHR _____BPM

PLACENTA

Location:

□ Anterior □ Posterior

□ Fundal □ Lateral R L

Position:

□ Normal/above os

□ low lying ____cm from internal os

□ Previa

AFI

Total:

_____**cm**

Max Vertical

Pocket:

_____ **cm**

Percentile range:

_____ **th**

%tile range (cm)

_____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

_____

_____

_____

_____