BPP ULTRASOUND

Name: _____ Date: _____

Physician: _____ DOB: ____/____/_____ Age: _____

Sonographer: _____

Clinical Indications: _____

LMP: _____ EDD: _____

VISUALIZED:	GESTATIONS	NONE	SINGLE	MULTIPLE_____
	FETAL PRESENTATION	CEPH	BREECH	TRANS
	CARDIAC ACTIVITY	YES	NO	_____ BPM
	4 CH HEART	YES	NO	
	3V CORD	YES	NO	_____ S/D RATIO
	NORMAL FLUID	YES	NO	_____ AFI

PLACENTA LOCATION	ANTERIOR	POSTERIOR	FUNDAL	
	HIGH	LOW		

PLACENTAL GRADE _____

PREVIA No Yes PARTIAL/MARGINAL

BIOPHYSICAL PROFILE:

FETAL BREATHING MOVEMENT _____
GROSS BODY MOVEMENT _____
FETAL TONE _____
QUALITATIVE AFV _____
TOTAL _____

Additional Comments: _____