

PELVIC ULTRASOUND

Transabdominal Transvaginal

Name: _____ Date: _____

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

Sonographer: _____

Clinical Indications: _____

Uterus: _____ cm (length) _____ cm (AP) _____ cm (trans)

Endometrium: _____ cm

Rt Ovary: _____ cm (length) _____ cm (AP) _____ cm (trans)

Normal Doppler Flow: YES NO

Lt. Ovary: _____ cm (length) _____ cm (AP) _____ cm (trans)

Normal Doppler Flow: YES NO

Free Fluid: NO YES

Additional Comments: _____

*****Any lesion which is measured must have image documentation of color Doppler flow*****