OB 2/3 TRIMESTER ULTRASOUND

Name: _____ Date: _____

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

Sonographer: _____

Clinical Indications: _____

LMP: _____

Gest Age by LMP: _____ wks _____ days

VISUALIZED:	GESTATIONS	☐ NONE	SINGLE	MULTIPLE_____		
	FETAL PRESENTATION	CEPH	BREECH	TRANS		
	PLACENTAL LOCATION	ANTERIOR	POSTERIOR	FUNDAL	PREVIA	MARGINAL/PARTIAL
	CARDIAC ACTIVITY	YES	NO	_____ BPM		
	4 CH HEART	YES	NO			
	3V CORD	YES	NO	_____ S/D RATIO		
	NORMAL FLUID	YES	NO	_____ AFI		
	KIDNEYS	YES	NO			
	STOMACH	YES	NO			
	BLADDER	YES	NO			
	SPINE	YES	NO			

BPD _____cm _____wks _____days **AC** _____cm _____wks _____days

HC _____cm _____wks _____days **FL** _____cm _____wks _____days

Estimated Gestational Age: _____ wks _____ days **Estimated Fetal Weight** _____grams

Additional Comments: _____

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