PELVIC ULTRASOUND

☐ Transabdominal ☐ Transvaginal

Name: _____ Date: _____

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

Sonographer: _____

Clinical Indications: _____

LMP:_____

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**********