

McLaren Print System Order

Order No: 57423 Reprint Previous Order No: 56252
 Order Date: 2020-10-06
 User: Deb House
 Phone: 989-269-8933 x4562

Ship Location: McLaren Thumb - main hospital/x-ray - attn: Deb House
 1100 South Van Dyke Rd
 Bad Axe, MI 48413

Forms

Quantity: 100
 Paragon Dept No: 27250
 Dept Name: Medical Imaging
 Company Number: 530

Order Total Price: 0.00

Item Number: 026.107
 Item Description: OB 2nd & 3rd Trimester
 Revision Date: 04/2016
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info: SS; BLACK; BOND PAPER

THUMB REGION
 1100 S. Van Dyke, Bad Axe, MI 48413

Ultrasound Department

2D, 3D & 4D TRIMESTER

Name: _____ UOI # _____

Referring Physician: _____ EDC _____

Date: _____ LMP: _____ Age: _____ G: _____ P: _____ 16 - 20 wks _____ 26 - 30 wks _____

Patient Exam: _____ Surgeries/C-Sections: _____

High Blood Pressure: _____ Diabetes: _____

Bleeding/Spotting/Discharge: _____ Hormones: _____

Indication: _____

Orientation:	Presentation:	Fetal Measurements	
<input type="checkbox"/> Single	<input type="checkbox"/> Vertex	BPD _____	CMF _____ wks
<input type="checkbox"/> Twin	<input type="checkbox"/> Breech	Head _____	CMF _____ wks
<input type="checkbox"/> Other	<input type="checkbox"/> Oblique	ABD _____	CMF _____ wks
	<input type="checkbox"/> Transverse	Pelvic _____	CMF _____ wks

Fetal Activity: _____ UOI: Yes No _____ Heart: Yes No _____ Heart Rate: _____

Biophysical Profile:	0	1	2	Fetal Movements
	0	1	2	Fetal Breathing
	0	1	2	Fetal Tone
	0	1	2	Amniotic Fluid Volume

APV Volume: _____ Total Biophysical Profile: _____

Placental Grading: I II III

Amniotic Fluid:	Placenta Position:	Placental Grading:
<input type="checkbox"/> Normal	<input type="checkbox"/> Anterior	RI, Lateral
<input type="checkbox"/> Oligoamnionic	<input type="checkbox"/> Fundal	LI, Lateral
<input type="checkbox"/> Polyamnionic	<input type="checkbox"/> Posterior	MI, Lateral
		Marginal
		Partial
		Grade _____ %

Previous Scans:	EDC:	Visualized	Fetal Anatomy:	Not Visualized
1. Date: _____	_____	<input type="checkbox"/>	4 Chamber Heart	<input type="checkbox"/>
2. _____	_____	<input type="checkbox"/>	Outflow Tracts R L	<input type="checkbox"/>
		<input type="checkbox"/>	Aorta	<input type="checkbox"/>
EFBW: _____	_____	<input type="checkbox"/>	Kidneys R L Both	<input type="checkbox"/>
EFW (Head/neck): _____	_____	<input type="checkbox"/>	Esophagus	<input type="checkbox"/>
EDC by US: _____	_____	<input type="checkbox"/>	Stomach	<input type="checkbox"/>
GA by US: _____	_____	<input type="checkbox"/>	Brain Ventricles	<input type="checkbox"/>
Geniv: _____	_____	<input type="checkbox"/>	Neck/Upper	<input type="checkbox"/>
		<input type="checkbox"/>	Spine	<input type="checkbox"/>
		<input type="checkbox"/>	B Vessel Cord / Cord Insertion	<input type="checkbox"/>

Diagnoses After Scan Comments: _____

Radiologist Signature: _____

026.107.04-16