McLaren Medical Group

FIRST TRIMESTER OBSTETRICAL ULTRASOUND

Date: _____

Patient Name: _____ Date of Birth: _____

Ordering Provider: _____

MEASUREMENTS

CRL mm/wks: _____

Yolk Sac: _____

# of Sacs: _____

Cardiac Motion: ❑ YES or ❑ NO

Right Adnexa: _____

Left Adnexa: _____

Placental Location: _____ Placenta Grade: _____

Cervical Length: _____

EDC by LMP: _____ EDC by SONO: _____

Comments: _____

_____

_____

Done By: _____ Date/Time: _____

Provider Comments: _____

_____

_____

Provider Signature: _____ Date/Time: _____