McLaren Medical Group

GYNECOLOGICAL ULTRASOUND

Date: _____

Patient Name: _____ Date of Birth: _____

Ordering Provider: _____

❑ Complete Pelvic	(76856)	Diagnosis: _____
❑ Transvaginal	(76830)	Diagnosis: _____
❑ Limited/Follow-up	(76857)	Diagnosis: _____
❑ Sonohysterogram	(58340)	Diagnosis: _____

Age: _____ LMP: _____ G: _____ P: _____

Previous Surgery: _____

MEASUREMENTS

Uterus: _____

Endometrial Canal: _____

Right Ovary: _____

Left Ovary: _____

Comments: _____

_____

_____

Done By: _____ Date/Time: _____

Provider Comments: _____

_____

_____

Provider Signature: _____ Date/Time: _____