

## McLaren Print System Order

Order No: 72729  
 Order Date: 2022-09-30  
 User: Deb House  
 Phone: 989-269-8933 x4562

Ship Location: McLaren Thumb Attn Deb House, Imaging  
 1100 S. Van Dyke Rd  
 Bad Axe, MI 48413

### Forms

Quantity: 100  
 Paragon Dept No: 27290  
 Dept Name: Ultrasound  
 Company Number: 530

Order Total Price: 0.00

Item Number: 026.106  
 Item Description: OB Ultrasound 1st Trimester  
 Revision Date: 10/2008  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: None  
 Poster:  
 Misc Info: SS; BLACK; BOND PAPER



**McLaren**  
 THUMB REGION  
 1100 S. Van Dyke • Bad Axe, Michigan 48413  
 989-269-9520 • Fax: 989-269-7948 • www.hummed.com

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**OB ULTRASOUND 1<sup>ST</sup> TRIMESTER**

Name \_\_\_\_\_ S. Ray # \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ EDC \_\_\_\_\_  
 Date \_\_\_\_\_ LMP \_\_\_\_\_ Age \_\_\_\_\_ G \_\_\_\_\_ P \_\_\_\_\_ AB + 20 wks \_\_\_\_\_ AB + 30 wks \_\_\_\_\_  
 Pelvic Exam \_\_\_\_\_ Surgeries/C Sections \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_  
 Bleeding/Spotting/Discharge \_\_\_\_\_ Hormones \_\_\_\_\_  
 Indication \_\_\_\_\_ Transducer Freq \_\_\_\_\_

Orientation	Presentations	Yes	No	Fetal Activity
<input type="checkbox"/> Single	<input type="checkbox"/> Vertex <input type="checkbox"/> Transverse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twin	<input type="checkbox"/> Breech <input type="checkbox"/> Umbilical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Oblique	<input type="checkbox"/>	<input type="checkbox"/>	Heart _____ Heart Rate _____

Gestational Sac Size \_\_\_\_\_ CM \_\_\_\_\_ wks  
 CRL \_\_\_\_\_ CM \_\_\_\_\_ wks  
 Yolk Sac \_\_\_\_\_

Amniotic Fluid	Placenta
<input type="checkbox"/> Normal	<input type="checkbox"/> Anterior <input type="checkbox"/> RL Lateral <input type="checkbox"/> Marginal
<input type="checkbox"/> Oligohydramnios	<input type="checkbox"/> Fundal <input type="checkbox"/> LL Lateral <input type="checkbox"/> Partial _____%
<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Posterior <input type="checkbox"/> Previa <input type="checkbox"/> Total

Sonographer's Impressions \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Spec Info:** EDC \_\_\_\_\_  
 1. \_\_\_\_\_ Device \_\_\_\_\_  
 2. \_\_\_\_\_ EDC by US \_\_\_\_\_  
 \_\_\_\_\_ SA by US \_\_\_\_\_

Diagnoses After Scan/Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Radiologist Signature \_\_\_\_\_

026.106.10-08