

McLaren Print System Order

Order No: 75984
 Order Date: 2023-03-21
 User: Deb House
 Phone: 989-269-9521

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: 026.107
 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
 Poster:
 Misc Info: SS; BLACK; BOND PAPER

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

Ultrasound Department

OB 2nd & 3rd TRIMESTER

Name: _____ MR # _____

Referring Physician: _____ EDC _____

Date: _____ LMP: _____ Age: _____ G: _____ P: _____ Ab + 20 wks _____ Ab + 20 wks _____

Pelvic Exam: _____ Surgeries/C Sections _____

High Blood Pressure: _____ Diabetes: _____

Smoking/Smoking/Discharge: _____ Hormones: _____

Indication: _____

Orientation:	Presentation:	BPO	Fetal Measurements
<input type="checkbox"/> Single	<input type="checkbox"/> Vertex	_____	CF _____ wks
<input type="checkbox"/> Twin	<input type="checkbox"/> Breech	_____	CF _____ wks
<input type="checkbox"/> Other	<input type="checkbox"/> Oblique	_____	CF _____ wks
	<input type="checkbox"/> Transverse	_____	CF _____ wks

Total Activity: _____

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

MR Volume: _____ Total Biophysical Profile: _____

Placental Grading: I 0 II

Amniotic Fluid:	Placenta Position:	R/L Lateral	Marginal
<input type="checkbox"/> Normal	<input type="checkbox"/> Anterior	<input type="checkbox"/> Lateral	<input type="checkbox"/> Marginal
<input type="checkbox"/> Oligoamnionic	<input type="checkbox"/> Fundal	<input type="checkbox"/> Lateral	<input type="checkbox"/> Marginal
<input type="checkbox"/> Polyhydramnionic	<input type="checkbox"/> Posterior	<input type="checkbox"/> Placenta	<input type="checkbox"/> Total _____ %

Previous Scans:	EDC:	Visualized	Fetal Anatomy:	Not Visualized
1. _____	_____	<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"/>
		<input type="checkbox"/>	Kidneys R L Both	<input type="checkbox"/>
		<input type="checkbox"/>	Extremities	<input type="checkbox"/>
		<input type="checkbox"/>	Bladder	<input type="checkbox"/>
		<input type="checkbox"/>	Stomach	<input type="checkbox"/>
		<input type="checkbox"/>	Brain Ventricles	<input type="checkbox"/>
		<input type="checkbox"/>	Spine/UPR	<input type="checkbox"/>
		<input type="checkbox"/>	Spine	<input type="checkbox"/>
		<input type="checkbox"/>	3 Vessel Cord / Cord Insertion	<input type="checkbox"/>

Diagnoses After Scan Comments: _____

Radiologist Signature: _____

026.107.04.16

Spec Info: