

McLaren Print System Order

Order No: 85180
 Order Date: 2024-05-02
 User: Deb House
 Phone: 989-269-1557

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: 3.35

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

OB/ULTRASOUND 1ST 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"/> Twin	<input type="checkbox"/> Breech	<input type="checkbox"/> Unstable	<input type="checkbox"/>	<input type="checkbox"/> LMB
<input type="checkbox"/> Other	<input type="checkbox"/> Oblique	<input type="checkbox"/>	<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"/> Oligohydramnios	<input type="checkbox"/> Fundal
<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Posterior
	<input type="checkbox"/> RL Lateral
	<input type="checkbox"/> LL Lateral
	<input type="checkbox"/> Placenta _____ %
	<input type="checkbox"/> Total

Sonographer's Impressions _____

Spec Info:
 1. _____ EDC _____ Date _____
 2. _____ EDC by US _____
 SA by US _____

Diagnosis After Scan Comments _____

Radiologist Signature _____

026.106.10-08