GUILFORD/MADISON RADIOLOGY

PELVIC ULTRASOUND

DATE_____

PATIENTS NAME: _____ DATE OF BIRTH: _____

MRN #:_____ REFERRING MD:_____

Reason for exam_____

Previous/History_____

☐ Transabdominal/Transvaginal for better visualization of _____

☐ Transabdominal/Transvaginal per physician order

LMP_____

TRANSABDOMINAL MEASUREMENTS

UTERUS_____X_____X_____cm VOL_____cc

Endometrium_____

RT OVARY_____X_____X_____cm ☐ Not seen

LT OVARY_____X_____X_____cm ☐ Not seen

TRANSVAGINAL MEASUREMENTS

UTERUS_____X_____X_____cm VOL_____cc

Endometrium_____

RT OVARY_____X_____X_____cm ☐ Not seen

LT OVARY_____X_____X_____cm ☐ Not seen

FREE FLUID YES/NO

SONOGRAPHER WORKSHEET ONLY: NOT OFFICIAL REPORT SONOGRAPHER_____ RAD_____