

McLaren Print System Order

Order No: 60987
 Order Date: 2021-03-15
 User: Deb House
 Phone: 989-269-8933 x4562

Ship Location: McLaren Thumb - main hospital/x-ray - attn: Deb House
 1100 South Van Dyke Rd
 Bad Axe, MI 48413

Forms

Quantity: 500
 Paragon Dept No: 27290
 Dept Name: Medical Imaging
 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
 Misc Info: SS; BLACK; BOND PAPER

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

Ultrasound Department

2ND & 3RD TRIMESTER

Name: _____ MR # _____

Referring Physician: _____ EDC _____

Date: _____ LMP: _____ Age: _____ G: _____ P: _____ 16 - 20 wks _____ 16 - 20 wks _____

Pelvic Exam: _____ Surgeries/C-Sections: _____

High Blood Pressure: _____ Diabetes: _____

Bleeding/Spotting/Discharge: _____ Hormones: _____

Indication: _____

Orientation:	Presentation:	Fetal Measurements
<input type="checkbox"/> Single	<input type="checkbox"/> Vertex	BPD _____ cm
<input type="checkbox"/> Twin	<input type="checkbox"/> Breech	Head _____ cm
<input type="checkbox"/> Other	<input type="checkbox"/> Oblique	ABD _____ cm
	<input type="checkbox"/> Transverse	Femur _____ cm

Fetal Activity: _____

Biophysical Profile:	Heart Rate:
0 1 2	0 1 2
Fetal Movements	Fetal Breathing
Fetal Tones	Amniotic Fluid Volume

APF Volume: _____

Placental Grading: 1 0 0

Amniotic Fluid:	Placenta Position:	Placental Grading:
<input type="checkbox"/> Normal	<input type="checkbox"/> Anterior	0 1 2
<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Fundal	
<input type="checkbox"/> Oligohydramnios	<input type="checkbox"/> Posterior	

Previous Scans:	EDC:	Visualized:	Not Visualized:
1. _____	_____	4 Chamber Heart	_____
2. _____	_____	Outflow Tracts R L	_____
EFBW: _____	_____	Aorta	_____
EFW (Head): _____	_____	Kidneys R L Both	_____
EDC by US: _____	_____	Esophagus	_____
Geniv: _____	_____	Bladder	_____
		Stomach	_____
		Brain Ventricles	_____
		Neck/Upper	_____
		Spine	_____
		B Vessel Cord / Cord Insertion	_____

Diagnoses After Scan Comments: _____

Radiologist Signature: _____

026.107.04-16

Spec Info: