AUCKLAND RADIOLOGY GROUP

OBSTETRIC ULTRASOUND

☐ MRS ☐ MISS ☐ MS	NAME	DATE OF BIRTH	NHI #
ADDRESS		TELEPHONE	TRIMESTER 1 2 3 4
		EDD	LMP

INDICATION CODE

- ☐ **TA** THREATENED ABORTION
- ☐ **EP** SUSPECTED ECTOPIC PREGNANCY
- ☐ **PM** PELVIC MASS IN PREGNANCY
- ☐ **UD** UTERUS NOT EQUAL TO DATES
- ☐ **BA** PRIOR TO BOOKING CVS OR AMNIOCENTESIS OR NUCHAL TRANSLUCENCY
- ☐ **CT** CONSIDERATION OF TERMINATION
- ☐ **NT** DATING AND EARLY EVALUATION FOR CHROMOSOMAL ABNORMALITY
- ☐ **NF** EARLY EVALUATION FOR CHROMOSOMAL ABNORMALITY
- ☐ **AN** ANATOMY
- ☐ **AF** ANATOMY FOLLOW UP
- ☐ **GR** SUSPECTED GROWTH ABNORMALITY (IUGR OR MACROSOMIA)
- ☐ **GF** SUSPECTED GROWTH ABNORMALITY (IUGR OR MACROSOMIA) FOLLOW UP
- ☐ **PL** CHECK PLACENTA
- ☐ **AH** ANTEPARTUM HAEMORRHAGE
- ☐ **AP** ABDOMINAL PAIN
- ☐ **MP** MALPRESENTATION
- ☐ **FC** SUSPECTED FETAL COMPROMISE
- ☐ **FD** SUSPECTED INTRAUTERINE FETAL DEATH
- ☐ **PP** MATERNAL POSTPARTUM

CLINICAL DETAILS

GRAVIDA

REFERRING PRACTITIONER

NZMC#

NZNC#

☐ **LMC**

☐ **EMERGENCY REFERRAL**

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SEND TO REFERRER	☐	☐
SEND TO PATIENT	☐	☐
GIVE TO PATIENT	☐	☐

PHONE REPORT TO

FAX REPORT TO

EDI REPORT TO

SIGNATURE	DATE
COPY OF REPORT TO	PATIENT CODE

YOU MAY HAVE YOUR FILMS DELIVERED IN A PLAIN ENVELOPE IF YOU WISH