Center For
WOMEN'S HEALTH
& WELLNESS

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Obstetrical Ultrasound

Patient: _____ Date: _____/_____/_____
DOB: _____/_____/_____ Physician: _____
Number of Fetus: _____ Presentation: _____
FHR: _____ LMP: _____
Indication: _____

Fetus A: Crown to Rump: _____ wks _____ days
Gest. Sac: _____ wks _____ days

Fetus B: Crown to Rump: _____ wks _____ days
Gest. Sac: _____ wks _____ days

Additional Comments:

_____

_____

_____

_____

Ins: _____ Technologist: _____

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