IMAGEN

PELVIC ULTRASOUND EVALUATION

Date: Name of Patient:

Patient ID #: Accn#: Ordering Provider:

Order Status: Exam Performed: ☐ TA ☐ TV ☐ Signed Consent Attached

☐ Regular ☐ Facility Unable to provide TV Images/Service not provided

☐ STAT Tristel HLD Event ID:

Reason for Exam (Symptoms/Indication): Choose or Type

Past Relevant Surgical History: Choose or Type

Past Relevant Medical History:

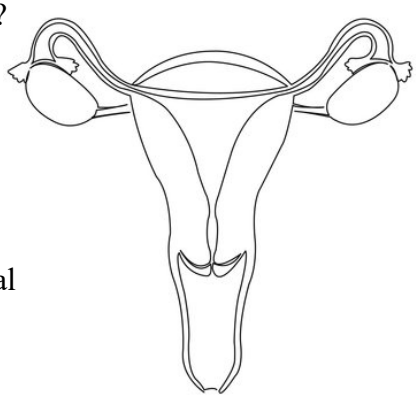
Previous Relevant Imaging Exams & Dates:

LMP: IUD: Choose Proper Placement: Choose Or Type

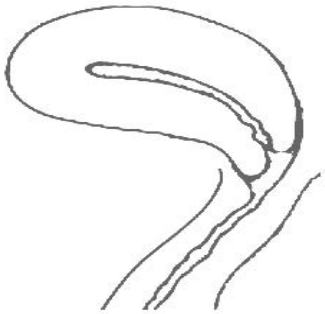
UT Mass seen?
Choose One

How Many?

Location:
☐ Submucosal
☐ Intramural
☐ Subserosal



Label Diagram by placing an X over any area of Pathology



Maternal History:

G

P

A

Uterine Position:
Choose One

Uterus: x x cm Please Select One

RT Ovary: x x cm Please Select One

LT Ovary: x x cm Please Select One

Endometrium: cm Please Select One

Adnexa: Please Select One

Comments:

Sonographer: Contact Phone Number: