IMAGEN

FOLLICLE TRACKING ULTRASOUND EVALUATION – FOLLOW UP

Date: _____ Name of Patient: _____

Patient ID #: _____ Accn#: _____ Ordering Provider: _____

Exam Performed: ☐ TV ☐ Signed Consent Attached (if applicable)

Order Status: ☐ Regular ☐ STAT ☐ Facility Unable to provide TV Images/Service not provided

Tristel HLD Event ID: _____ (if applicable)

LMP: _____ Cycle Day: _____

Uterus: _____ (L) x _____ (AP) x _____ (W) cm Please Select One

Endometrium: _____ cm Please Select One *(must be measured on serial exams)*

Rt Adnexa: Please Select One Lt Adnexa: Please Select One

CDS: Please Select One

RT OVARY

_____ (L) x _____ (AP) x _____ (W) cm Please Select One

Total follicle count: _____ Follicles >10 mm: _____

Largest follicles (3-5, if >10mm)

	Plane 1	Plane 2	Mean
1.	_____ x	_____ cm	_____ mm
2.	_____ x	_____ cm	_____ mm
3.	_____ x	_____ cm	_____ mm
4. *(optional)*	_____ x	_____ cm	_____ mm
5. *(optional)*	_____ x	_____ cm	_____ mm

LT OVARY

_____ (L) x _____ (AP) x _____ (W) cm Please Select One

Total follicle count: _____ Follicles >10 mm: _____

Largest follicles (3-5, if >10mm)

	Plane 1	Plane 2	Mean
1.	_____ x	_____ cm	_____ mm
2.	_____ x	_____ cm	_____ mm
3.	_____ x	_____ cm	_____ mm
4. *(optional)*	_____ x	_____ cm	_____ mm
5. *(optional)*	_____ x	_____ cm	_____ mm

Measure previously identified follicles >10mm in 2 scan planes and provide the mean. Example: 1.2 x 1.4 cm Mean: 13mm

Comments:

Sonographer: _____ Contact Phone Number: _____