IMAGEN

FOLLICLE TRACKING ULTRASOUND EVALUATION

Date: _____ Name of Patient: _____

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

Exam Type: ☐ Initial ☐ Follow up Exam Performed: ☐ TA ☐ TV ☐ Signed Consent Attached

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

Tristel HLD Event ID: _____ Uterine Position: Choose One

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

Past Relevant Surgical History: Choose or Type

Past Relevant Medical History: _____

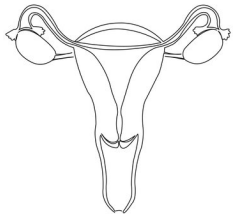
Previous Relevant Imaging Exams & Dates: _____

LMP: _____ Cycle Day: _____ Maternal History: G_____ P _____ A_____

UT Mass seen? Choose One

How many? _____

Location:
- ☐ Submucosal
- ☐ Intramural
- ☐ Subserosal



Label Diagram by placing an X over any area of Pathology



Document the 2 largest fibroids:

Fibroid 1

_____ x _____ x _____ cm
L AP W

Fibroid 2

_____ x _____ x _____ cm
L AP W

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

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

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

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

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

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 in 2 scan planes and provide the mean. Example: 1.2 x 1.4 cm Mean: 13mm

Comments:

Sonographer: Contact Phone Number: