Form 8. Obstetric ultrasound form PREG

Used for ANV at GA 26-28 and GA 34-36, US controls, extra ANV and EMR visit were US is needed.

8.1. Antenatal Clinic location: ☐ Korogwe Town Council hospital ☐ Other

8.1.1. If other, specify:_____

8.2. Ultrasonographer's name: _____

8.3. Date (dd/mm/yyyy): _ _ / _ _ / _ _

8.3.1. **Gestational age by US** _ _ Weeks _ _ days

8.4. Type of visit ☐ ANV ☐ Extra ANV ☐ EMR ☐ only US

8.4.1. **Number of this type of visit** (incl. today) _ _

8.4.2. **Specify reason for US if not regular ANV** (GA 26-28 and GA 34-36):

☐ AFI ctr ☐ overdue ☐ctr. Praevia ☐ IUGR suspected ☐ vaginal bleeding
☐Maternal disease ☐ decreased fetal movement ☐ abdominal trauma ☐ other

8.4.3.If other, specify: _____

8.5. Has CRF3 been filled ☐yes ☐no

FETUS condtion

8.6. Position/presentation ☐ Breech ☐ Head ☐ Limb ☐NA

8.7. Fetal lie: ☐ Longitudinal ☐ Oblique ☐ transverse

8.8. Cardiac activity ☐yes ☐no

8.9. Active Movements ☐yes ☐no

		1st (a)	2nd (b)	**Average** (c)
8.10	BPD (biparietal diameter)	_ _ _ mm	_ _ _ mm	_ _ _ mm
8.11	OFD (Occipito-frontal diameter)	_ _ _ mm	_ _ _ mm	_ _ _ mm
8.12	HC (Head circumference)	_ _ _ mm	_ _ _ mm	_ _ _ mm
8.13	TTD (abdominal transverse diameter)	_ _ _ mm	_ _ _ mm	_ _ _ mm
8.14	APTD (abd. dia. anterior - posterior)	_ _ _ mm	_ _ _ mm	_ _ _ mm
8.15	AC (abdominal circumference)	_ _ _ mm	_ _ _ mm	_ _ _ mm
8.16	FL (femur length)	_ _ mm	_ _ mm	_ _ mm
8.17	Foetal weight (Hadlock I (HC, AC, FL))			_ _ _ _ g
8.18	Deviation from mean, if below mean			__,_ %

If only one biometric measurement put in 1st and leave 2nd blank

8.19. **Placenta position** ☐anterior ☐posterior ☐fundal

8.20. **Amniotic fluid** ☐oligohydr ☐normal ☐polyhydramn.

8.20.1. 1st quandrant (right, upper): _ _ , _ cm

8.20.2. 2nd quadrant (left, upper): _ _ , _ cm

8.20.3. 3rd quadrant (rigth, lower): _ _ , _ cm

8.20.4. 4th quadrant (left, lower): _ _ , _ cm

8.20.5. Total: _ _ , _ cm

CONCLUSIONS:

8.21. Noted any abnormalities:

8.21.1. Fetal death in utero: ☐yes ☐no

8.21.2. Placental insertion low (placenta praevia) ☐yes ☐no

8.21.3. Abnormal volume of amniotic fluid ☐yes ☐no

8.21.4. SGA diagnosed (more than -15% of expected weight) ☐yes ☐no
If below 10th percentile on reference intergrowth chart

8.21.5. Other: _____

8.22. Take a decision:

8.22.1. Normal follow-up: ☐yes ☐no

8.22.2. Repeat ultrasound necessary: ☐yes ☐no

8.22.3. Refer to specialist: ☐yes ☐no

Next visit booked on: _ _ / _ _ / _____, specify visit type: _

DATA ENTRY:

1st entry done by:_____ Signature:_____ date:_ _/_ _/_ _ _ _

2nd entry done by:_____ Signature:_____ date:_ _/_ _/_ _ _ _