

MATRIX-007/CARE PrEP Ultrasound Scan Form

Participant Name:	Age:	First day of last menstrual period (LMP): / / DD/MMM/YYYY
Date of Service: DD/MMM/YYYY / /	Facility where ultrasound was performed:	Sonographer Name:

First Trimester					
<input type="checkbox"/> Transvaginal <input type="checkbox"/> Transabdominal	Gestational sac visualized: <input type="checkbox"/> No <input type="checkbox"/> Yes → Gestational sac diameter (mean if possible): _____ mm				
Yolk sac: <input type="checkbox"/> Yes <input type="checkbox"/> No	Presence of embryo documented: <input type="checkbox"/> No <input type="checkbox"/> Yes → Number of sacs/embryos/fetuses: _____				
Embryo/Fetus:	Fetus 1 <input type="checkbox"/> N/A	Fetus 2 <input type="checkbox"/> N/A	Fetus 3 <input type="checkbox"/> N/A		
Cardiac activity:	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent		
Crown Rump Length (CRL) (mm):					
Summary					
Intrauterine pregnancy (IUP): <input type="checkbox"/> Yes <input type="checkbox"/> No	Viable: <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated GA Based on ultrasound (US): Wks _____ Days _____	Consistent with LMP: <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated due date (EDD) based on US: / / DD/MMM/YYYY	
Comments/other findings:					

Second/Third Trimester			
Fetal number: _____	Fetus 1 <input type="checkbox"/> N/A	Fetus 2 <input type="checkbox"/> N/A	Fetus 3 <input type="checkbox"/> N/A
Cardiac activity:	<input type="checkbox"/> Absent <input type="checkbox"/> Present → fetal heart rate: _____	<input type="checkbox"/> Absent <input type="checkbox"/> Present → fetal heart rate: _____	<input type="checkbox"/> Absent <input type="checkbox"/> Present → fetal heart rate: _____
Placental location:	<input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Previa <input type="checkbox"/> Low-lying	<input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Previa <input type="checkbox"/> Low-lying	<input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Previa <input type="checkbox"/> Low-lying
Amniotic fluid index or Deepest vertical pocket (mm)	<input type="checkbox"/> AFI <input type="checkbox"/> DVP measure: _____	<input type="checkbox"/> DVP measure: _____	<input type="checkbox"/> DVP measure: _____
Biparietal diameter (BPD) (mm)			
Abdominal circumference (AC) (mm)			
Femur length (FL) (mm)			
Estimated GA based on of the above three fetal parameters (BPD, AC, FL):	Wks _____ Days _____	Wks _____ Days _____	Wks _____ Days _____
Summary			
Estimated due date (EDD) based on US: / / DD/MMM/YYYY	Comments/other findings:		

Completed by CARE PrEP Study Staff

Final EDD: / / DD/MMM/YYYY	Notes:
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