The ULTRA SOUND Lab

Dr. Rohini Agrawal
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Reg. No. 41677 of 2013 (BMC)

Pt Name :-	Afreen Bano	Age :-	26 Yr/ F
Ref. By :-	Dr.V B Golwara DGO,MS	Date :-	02.09.2021
USG :-	FWB (NT Scan)		

Uterus is gravid.
Single live intrauterine fetus seen in variable position at the time of scan.
Fetal cardiac activity is present. FHR is 158 bpm.

Placenta thickening (decidual) is seen posteriorly.
Liquor is adequate. Largest vertical pocket measures 1.4 cm.

CRL	4.65 cm	11 wk 3d

Nuchal translucency is normal and measures 1.3 mm.
Nasal bone measures 1.8 mm.

All four limb buds are visualised.
No major limb reduction seen.
Falx cerebri visualised.
Flow in ductus venosus appears normal.

Internal os is closed.
Cervical length is adequate and measures 3.9 cm.

Average gestational age by USG: 11 wk 3d ± 2 wk
EDD by USG: 21/03/2022.

Mrs. Afreen Bano declare that by undergoing USG, I do not want to know the sex of my fetus.

आफरीन बानो
Signature of the Patient

Dr. Rohini Agrawal, hereby declare that I have neither detected nor disclosed the sex of the fetus to anybody, in any manner.

Signature of the Radiologist

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REQUEST FORM FOR MATERNAL SCREENING

- [x] DOUBLE MARKER — 1st TRIMESTER (9-13 WEEKS)
- [ ] TRIPLE MARKER — 2nd TRIMESTER (15-21 WEEKS)
- [ ] QUADRUPLE MARKER — 2nd TRIMESTER (15-21 WEEKS)

(PLEASE TICK TEQUESTED TEST)

PATIENT DETAILS

Name: AFREEN BANO

Date of Birth (DD/MM/YY) : 15/09/1995

Lab Reference No. : 25738783

Accession No. : _____

(For Lab Use Only)

Date of Sample Collection : 03/09/2021

Referring Clinician (Name & Contact No.): DR. V. B. GOLWARA

Maternal Weight: 71.3 kg

Maternal History:

Diabetes : ☐ Yes ☑ No

Smoking : ☐ Yes ☑ No

Race / Ethnicity : ☑ Asian ☐ African ☐ Caucasean ☐ Others: _____ (Please specify)

Initial Screening : ☑ Yes ☐ No

Repeat Testing : ☐ Yes ☐ No

Previous Pregnancy: History of Down's Syndrome/Trisomy 18/Trisomy 13/Neural Tube Defect / any other anomaly NO

Family History: History of Down's Syndrome/Trisomy 18/ Trisomy 13/Neural Tube Defect/any other anomaly NO

History of Assisted Reproduction/IVF : ☐ Yes ☑ No

If Yes, Egg Source: ☐ Own Eggs ☐ Donor Eggs

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REQUEST FORM FOR MATERNAL SCREENING (Contd.)

If Donor Eggs,

Donor's Date of Birth (DD/MM/YY): ___/___/____

Procedure Type: _____

Extraction Date (DD/MM/YY): ___/___/____

Transfer date (DD/MM/YY): ___/___/____

Ultrasound details

(Photocopy of Ultrasound report is mandatory with the sample)

Date of USG Report (DD/MM/YY) : 02/09/2021.

Radiologist/Sonologist (Name & Contact No.): DR. ROHINI AGRAWAL.

Qualification of Radiologist/Sonologist: MD (Radio.)

Association with NT Certifying Organisation e.g Foetal Medicine foundation:

FMF ID:

Mean Gestational Age: 11 WKS 3 DAYS.

Number of Fetus: SINGLE.

Crown Rump Length (CRL): 4.65 c.m.

(Acceptable: 38-84mm)- Mandatory for USG conducted in First Trimester

Nuchal Translucency (NT): 1.3 m.m.

(Acceptable: 0.1- 6.0 mm)- Mandatory for USG conducted in First Trimester

Nasal Bone: ☑ Present ☐ Absent ☐ Not Examined
Examined

Biparietal Diameter (BPD): Attached USG Copy.

(Acceptable: 26-52 mm)

Foetal Length (FL):

3114 वी वर्मा

Name & Dated Signature of Patient

03/09/2021

Name & Dated Signature of Requisitioner