ALL INDIA INSTITUTE OF MEDICAL SCIENCES, JODHPUR

Department of Diagnostic and Interventional Radiology

REQUISITION FORM FOR ANTENATAL ULTRASOUNDS

Patient name: **Husband name:**	**Age** **AIIMS HIS ID**	**OPD / IPD** **Bed no** **Requisition date** **Emergent / Urgent / Routine** **MLC…… Yes / No**
Name of Referring Physician:		
LMP date: ……Known / Unknown **LMP:** **EDD:** **GA according to LMP:** **GA according 1st trimester USG if available:** **Suspected early onset FGR: ……Yes / No / NA** **Suspected late onset FGR / SGA: ……Yes / No / NA**		
Prior Obstetric History:		
Any congenital anomalies in previous pregnancy: **Genetic evaluation in previous pregnancy:** **Drug / Medical history of mother:** **History of vaginal bleeding / leaking:**		
Visit in AIIMS: **First / Follow up** **Previous USG details if available:** **Previous normal / abnormal Doppler:**		
USG Request for (pl tick) **1. Confirmation of Pregnancy** **2. NT / NB scan** **Dual Marker Yes / No** **Invasive testing (if done) Yes / No** **3. Level II scan** **Quadruple Marker Yes / No** **4. Fetal Echocardiography** **5. Fetal Well Being Growth Scan** **6. Antenatal Doppler** **Indication** **7. Placental localization** **8. Any other…… (pl specify)**		
Name of requesting doctor: **Designation:** **Signature:** **Seal:** **Name of Consultant in-charge:** **RMC registration number:**	**FOR RADIOLOGY DEPT (Seal and date)**	