New Wave Ultrasound

351 Devon Street West
New Plymouth 4310
Phone 06-927 4345
Fax 06-927 4396

Name: _____ DOB:_____

Address: _____Phone:_____

_____

NHI (compulsory for maternity scans): _____

Maternity:

(Circle One)

Uterus not equal to dates
TOP
Threatened Miscarriage
Ectopic
Nuchal Translucency (NT)
NT Follow-up
Dating prior to TOP
Anatomy
Anatomy Follow-up
? Pelvic Mass
Antepartum Haemorrhage
Abdominal pain
Growth
Growth Follow-up
Placental Site
Presentation
Fetal Compromise
Fetal Demise
RPOC

General:

(Circle One)	Neck	Carotid	Shoulder
Abdomen	Thyroid	DVT	Foreign body
Pelvis	Testes	Vein Mapping	Groin/Hernia
Renal	Renal Arteries	Limb Arterial Doppler	MSK - Other

ACC Number:

Clinical Information

Maternity Scans: LMP:_____EDD:_____

Referrer: _____ Copies to: _____

NZMC/NZCONNZ: _____

Signed: _____ Date: _____