

COMMENTS

- Affix label here-

Clinical Center/ID: _____

First Name _____ M.I. _____

Last Name _____

1. Contact Date: _____ (M/D/Y)

2. Requested By: _____

3. Contact Type:

☐₁ Phone☐₂ Mail☐₃ Visit☐₈ Other

4. Visit Type:

☐₁ Screening # _____☐₂ Semi-Annual # _____☐₃ Annual # _____☐₄ Non-Routine

5. Date of transvaginal uterine ultrasound:

_____ (M/D/Y)

6. Transvaginal uterine ultrasound performed by:

Name _____

Address _____

City/State/Zip _____

Phone: _____

7. Date report reviewed:

_____ (M/D/Y)

8. Report reviewed by:

9. Summary of report:

☐₁ Endometrial thickness $\leq$ 5 mm☐₂ Endometrial thickness > 5 mm☐₃ Unable to evaluate thickness due to leiomyomata☐₄ No uterus seen☐₉ Unable to perform successfully or participant refused

10. Pelvic pathology present?

☐₀ No ☐₁ Yes 

	No	Yes
10.1. Polyps	☐ ₀	☐ ₁
10.2. Uterine mass	☐ ₀	☐ ₁
10.3. Pelvic fluid	☐ ₀	☐ ₁
10.4. Ovarian mass	☐ ₀	☐ ₁
10.5. Other	☐ ₀	☐ ₁

10.5.1. Side:
☐₁ Right ☐₂ Left ☐₃ Both

11. Other pathology present outside the reproductive structures?

☐₀ No☐₁ Yes (Specify): _____

12. Was significant endometrial cavity fluid seen?

☐₀ No☐₁ Yes

13. Was a referral made for follow-up care?

☐₀ No☐₁ Yes 

13.1. Referred by: _____

13.2. Date of referral: _____ (M/D/Y)

13.3. Referred to: _____

13.4. Endometrial follow-up results

☐₀ Normal☐₁ Hyperplasia☐₂ Cancer

13.5. Pelvic pathology follow-up results

☐₀ Normal/benign☐₁ Cancer

K _____ V _____