

# Bethlehem ULTRASOUND



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PATIENT		ADDRESS		<b>OBSTETRIC</b> <input type="checkbox"/> DATING <input type="checkbox"/> NUCHAL <input type="checkbox"/> ANATOMY <input type="checkbox"/> GROWTH <input type="checkbox"/> BPP / DOPPLERS			
DOB		NHI					
COPY TO		PHONE					
<b>CLINICAL BACKGROUND</b>				<b>MUSCULOSKELETAL FREE ACC</b>			
EDD LMP CODE				<input type="checkbox"/> SHOULDER <input type="checkbox"/> WRIST <input type="checkbox"/> ANKLE <input type="checkbox"/> KNEE <input type="checkbox"/> HIP <input type="checkbox"/> OTHER <input type="checkbox"/> ABDOMINAL <input type="checkbox"/> PELVIS <input type="checkbox"/> RENAL <input type="checkbox"/> ABDO/PELVIS <input type="checkbox"/> THYROID <input type="checkbox"/> TESTES <input type="checkbox"/> HERNIA <input type="checkbox"/> OTHER <input type="checkbox"/> BREAST			
				<input type="checkbox"/> DVT <input type="checkbox"/> CAROTID <input type="checkbox"/> ARTERIAL <input type="checkbox"/> VENOUS <input type="checkbox"/> AORTA			
				<input type="checkbox"/> ACC #			
				<b>REFERRING SPECIALIST</b>		<b>NZMC/NZONC</b>	
				DATE			
SIGNATURE							