



EXAMINATION REQUEST

Patient:

Examination:

Please tick the required scan/s-

- ☐ **Ultrasound Pregnancy- 8-10 Weeks- For Dates and First Trimester Screening (FTS) Blood Test**
- ☐ **Ultrasound Pregnancy- 12-13 Weeks- For Nuchal Translucency**
- ☐ **Ultrasound Pregnancy- 20 Weeks- For Fetal Morphology**
- ☐ **Ultrasound Pregnancy- Third Trimester- For Fetal Wellbeing and Placenta**

Clinical Details:

LMP:

EDD:

Copy To:

Signature:

Date:

UNIVERSAL MEDICAL IMAGING

1/110 Giles Street (Corner Printers Way) Kingston Foreshore ACT 2604

Ph: **(02) 6126 5000** Fax: **(02) 6239 4242**

Bookings between **8.30 am** and **5.30 pm**