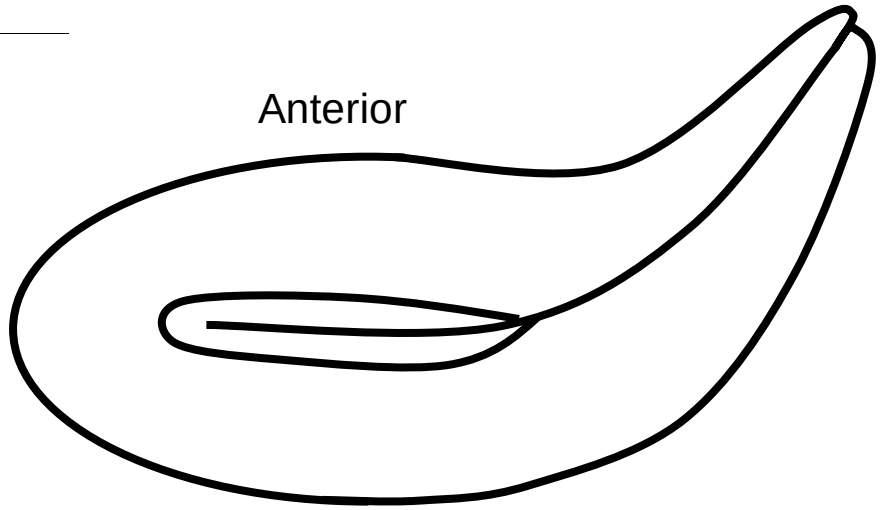
This is NOT an interpretation of the examination.
See patient dictated report for radiologist findings & impression.

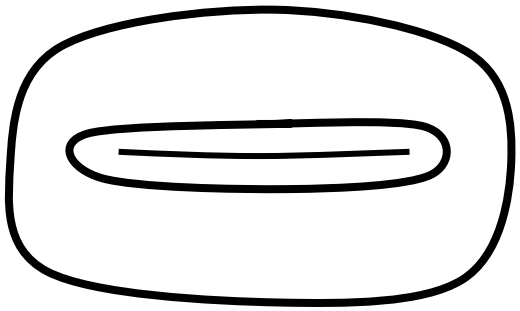
FIBROID MAP

Patient Name: _____
ACC#: _____
MRN#: _____
DOB: _____
Ref Physician:

Site: _____
Tech/ext: _____
Date: _____



Anterior Posterior



Posterior

Uterus L_____AP_____W_____

Endometrial Thickness_____

Number of Fibroids: _____

Largest Diameter

1. _____
2. _____
3. _____
4. _____

Right ovary L_____AP_____W_____

Ov Vol _____# of foll <12 >12 Foll location: perif diff

Left ovary L_____AP_____W_____

Ov Vol # of foll <12 >12 Foll location: perif diff