NUCHAL TRANSLUCENCY – IMAGE REVIEW SHEET

For each criteria item place a: Check Mark to indicate YES/ "X" to indicate No/ N/A to indicate Not Applicable

Facility Name/IHF No._____

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Patient Identifier (Exam #, Patient Initials)					
Examination Date					
Examination Clinically Indicated					
Has the examination been done within the 11.5 – 13 week timeframe?					
Tech worksheets complete and signed					
Physician Interpretation Complete as per CPP's					
Record interpreting physician /technologist (initials)					
Image Quality – Diagnostic/Undiagnostic					

Comments:

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5

NOTE: To be done as part of the General Ultrasound review if applicable. Minimum of 3 of the 15 ultrasound images.