



**PART A: TRANSVAGINAL ULTRASOUND EXAMINATION FINDINGS**

QUESTION	RIGHT	LEFT
<b>1. Sonographically Detectable Ovary</b>	<input type="radio"/> No (GO TO 3) <input type="radio"/> Yes	<input type="radio"/> No (GO TO 3) <input type="radio"/> Yes
<b>2. Ovary Size</b> (CALCULATE VOLUME: WIDTH X HEIGHT X THICKNESS X 0.523)	Longitudinal diameter (cm): ____ . ____ Transverse diameter (cm): ____ . ____ Anteroposterior diameter (cm): ____ . ____ Volume (cc): _____ . ____	Longitudinal diameter (cm): ____ . ____ Transverse diameter (cm): ____ . ____ Anteroposterior diameter (cm): ____ . ____ Volume (cc): _____ . ____
<b>3. Number of Morphologic Abnormalities in Adnexal Area</b>	<input type="radio"/> None (GO TO LEFT) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three or more	<input type="radio"/> None (GO TO 5) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three or more
<b>4. Complete for Three Largest Discrete Cysts or Abnormalities:</b>		
<b>A. Maximum Diameter of Cyst or Abnormality (in cm.)</b>	#1: ____ . ____ #2: ____ . ____ #3: ____ . ____	#1: ____ . ____ #2: ____ . ____ #3: ____ . ____
<b>B. Volume of Cyst or Abnormality (in cc.)</b> CALCULATE VOLUME: [MAXIMUM DIAMETER] <sup>3</sup> x 0.523	#1: _____ . ____ #2: _____ . ____ #3: _____ . ____	#1: _____ . ____ #2: _____ . ____ #3: _____ . ____
<b>C. Solid Area</b> 0 = None 1 = Mixed 2 = All Solid (GO TO 4G)		
<b>D. Septal Structure</b> 0 = No septae 1 = Yes, thin (≤3mm) 2 = Yes, thick (>3mm)		
<b>E. Cyst Outline</b> 1 = Smooth 2 = Irregularities 3 = Papillarities		
<b>F. Cyst Wall Thickness</b> 1 = Thin (≤3mm) 2 = Thick (>3mm)		
<b>G. Echogenicity</b> 1 = Sonolucent 2 = Low 3 = Low with echogenic core 4 = Mixed 5 = High		

**5. Other Abnormalities Noted:**

- No
- Yes (SPECIFY)

**PART B: EXAMINATION RESULTS**

**1. Examination Result:**

- Positive Screen – Referral Required (GO TO 3)
- Negative Screen – No Abnormalities (GO TO 3)
- Negative Screen – Other Abnormalities (GO TO 3)
- Inadequate

**2. Reason for Inadequate Exam: (MARK ALL THAT APPLY)**

- Participant Discomfort
- Participant Refusal
- Equipment Malfunction
- Inability to Insert Probe
- Bowel Interference
- Other (SPECIFY)

**3. Level of Referral:**

- 1 – Significant Abnormality, Referral
- 2 – Moderate Abnormality, Referral
- 3 – Slight Variation from Normal, No Referral
- 4 – Normal/Result Not Available, No Referral

**4. Photo Documentation:**

- No
- Yes

**5. Medical Complications of Examination**

- No
- Yes (SPECIFY)

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**6. COMMENTS:**

- No
- Yes (SPECIFY)

Item #	Comments

(CONTINUED)

**7. Examiner ID:** \_\_\_\_\_

**8. Consultant ID:**

- No
- Yes (SPECIFY) \_\_\_\_\_

**FOR OFFICE USE ONLY**

**Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)**

- Form Receipted into SMS
- Manual Review Completed

**Data Entry of Non-Scannable Items:**

- Completed OR
- None Required

**Data Retrieval:**

- Attempted OR
- None Required

**Disposition:**

- Final Complete (FCM) OR
- Final Incomplete (FIC)