



KU POCUS PROJECT POCUS REFERRAL TRACER FORM

Facility name _____
County _____

This form should be completed in duplicate and a copy retained in the POCUS book and the other pinned to the patient's booklet for all patients who are referred after POCUS.

ALL PATIENTS REFERRED AFTER POCUS SHOULD BE REQUESTED TO BRING FEEDBACK IN FORM OF COMPREHENSIVE SCAN REPORT OR DISCHARGE SUMMARY DURING NEXT ANC OR PNC ATTENDANCE

Date _____
Patient name: _____ Age: _____ Tel: _____
LMP- _____ EDD _____
Calculated gestation age in weeks _____
Next of kin name _____ Tel _____
Referred to _____

1. Your POCUS finding

- | | | |
|--|--|--|
| <input type="checkbox"/> Presentation | <input type="checkbox"/> Cephalic | <input type="checkbox"/> Non-cephalic |
| <input type="checkbox"/> Fetal heart beats | <input type="checkbox"/> Present | <input type="checkbox"/> Absent |
| <input type="checkbox"/> Fetal heart rate | <input type="checkbox"/> Normal (110 - 160bpm) | <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Number of fetuses | <input type="checkbox"/> Single | <input type="checkbox"/> Multiple |
| <input type="checkbox"/> Liquor amount | <input type="checkbox"/> (normal (<2 cm, >8 cm) - | <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Placenta | <input type="checkbox"/> Normally placed | <input type="checkbox"/> Abnormally placed |

2. Reason for referral/referral location

- Comprehensive US (at same facility)
- Comprehensive US (at other facility- specify which one)
- Other facility for specialist/high risk ANC follow-up specify which facility
- Other facility for delivery specify which facility
- Others reasons for referral (specify reason and to which facility)

Brief summary of feedback from facility referred from the comprehensive scan report or discharge summary

Provider referring _____

Signature _____