



Study Subject Number

0 7 - [][][][]

Visit Date

[D][D] - [M][M] - [Y][Y]

Study Antenatal Clinic Code

[][]

Date of Birth

[D][D] - [M][M] - [Y][Y]

Section 1: Abnormalities observed in ultrasound examination

In which of the following areas where the abnormalities seen?

Please provide detailed information in the text box for any abnormality where yes is crossed

- | | | | | | |
|----------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Head | <input type="checkbox"/> yes | <input type="checkbox"/> no | 9. Bladder | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 2. Brain | <input type="checkbox"/> yes | <input type="checkbox"/> no | 10. Limbs | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 3. Face | <input type="checkbox"/> yes | <input type="checkbox"/> no | 11. Lungs/Pleura | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 4. Neck | <input type="checkbox"/> yes | <input type="checkbox"/> no | 12. Kidneys | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 5. Spine | <input type="checkbox"/> yes | <input type="checkbox"/> no | 13. Genitalia | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 6. Heart | <input type="checkbox"/> yes | <input type="checkbox"/> no | 14. Chromosomal abnormality
(following amniocentesis or CVS) | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 7. Anterior abdominal wall | <input type="checkbox"/> yes | <input type="checkbox"/> no | 15. Two vessel cord
(single umbilical artery) | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 8. Gastro-intestinal | <input type="checkbox"/> yes | <input type="checkbox"/> no | 16. Other | <input type="checkbox"/> yes | <input type="checkbox"/> no |

17 Detailed Information

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18 Diagnosis

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Once completed please Fax or Scan and email a copy of this form to the Coordinating Unit in Oxford

Name of Researcher

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Signature

Researcher Code

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