Ultrasound Imaging Concepts

5860 S. Cooper St., #100, Arlington, TX
817-465-8439 Fax 888-968-8439

REFERRAL/ORDER FOR ULTRASOUND

Patient Name: _____

Date of Birth: _____ Phone #: _____

Referring Provider: _____

Appointment Date: _____ Appointment Time: _____

Referring Provider Phone/Fax: _____

Obstetrics/Gynecology

- ☐ 1st Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ Biophysical Profile
- ☐ Pelvis
- ☐ Transvaginal

Abdomen/Small Part

- ☐ Abdomen (GB/Liver)
- ☐ Renal
- ☐ Aorta
- ☐ Thyroid
- ☐ Scrotum
- ☐ _____

Cardiac and Vascular

- ☐ Diagnostic Echocardiogram
- ☐ Screening Echo/EKG (asymptomatic only)
- ☐ Carotid Duplex
- ☐ Venous Duplex (LE)
- ☐ Arterial Duplex (LE)
- ☐ _____

Reason for Exam (symptoms/diagnosis): _____

_____

Special Instructions: _____

_____

Preparation Instructions- **Abdominal Ultrasounds**: Nothing to eat or drink after midnight. **Pelvic Ultrasound**: Full bladder required. Drink 32 oz. of water 45 minutes prior to test.

Provider's Signature _____

EXAMINATION REQUESTED