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

REFERRAL/ORDER FOR ULTRASOUND

Patient Name: ____

Patient Address: ____

Date of Birth: ____________________ Phone #: __________________

Patient Email: ____

Referring Provider: ____

Referring Provider Phone: _________________FAX:__________________

☐ Self Pay
☐ Insurance
Primary Insurance: ______________________________
ID: ______________Group: _____________
Diagnosis/ICD 10 Code: ___________________________
Policy Holder: __________________ DOB: __________

EXAMINATION

Obstetrics/Gynecology

- ☐ 1st Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ Biophysical Profile
- ☐ Biophysical Profile with measurements
- ☐ 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): ____

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Previous Ultrasound ☐Yes ☐No Date: ______________________________

Special Instructions: ____

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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 exam.

Provider's Signature ____