5860 S. Cooper St., #100, Arlington, TX
(O) 817-465-8439 (F) 888-968-8439

REFERRAL/ORDER FOR ULTRASOUND

Patient Name: ____

Patient Address: ____

Date of Birth: ___________________________ Phone #: ________________________

Patient Email: ____

Referring Provider: _______________________ Providers NPI #_______________________

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 Complete
- ☐ Liver-Gallbladder-RUQ
- ☐ 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): ____

____

Previous Ultrasound ☐ Yes ☐ No Date: ______________________________________

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 exam.

Provider's Signature ____**Date** _______________________