5860 S. Cooper St.
Suite#100
Arlington, TX 76065
(O) 817-465-8439 (F) 888-968-8439
ultraviewimaging@live.com

REFERRAL/ORDER FOR ULTRASOUND

Patient Name: ____

Patient Address: ____

Date of Birth: ______________________ **Phone #:** ______________________

Patient Email: ____

Referring Provider: ____________________ **Providers NPI #**____________________

Referring Provider Phone: ____________________**FAX:**____________________

PLEASE COMPLETE

☐ **Self Pay**
☐ **Insurance**

Primary Insurance: ______________________________________

ID: ____________________**Group:** ____________________

Diagnosis/ICD 10 Code: 1.____________ **2.**____________ **3.**____________

Policy Holder: ______________________ **DOB:** ______________

EXAMINATION

Obstetrics/Gynecology

- ☐ 1St Trimester
- ☐ 2nd & 3rd Trimester
- ☐ 3rd Trimester
- ☐ F/U OB
- ☐ Biophysical Profile
- ☐ BPP W/Measurements
- ☐ Pelvis
- ☐ Transvaginal or Pelvic

Abdomen/Small Part

- ☐ Abdomen Complete
- ☐ Liver-Gallbladder-RUQ
- ☐ Renal
- ☐ Aorta
- ☐ Thyroid
- ☐ Scrotum
- ☐ Breast RT
- ☐ Breast LT

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:** ______________________________

Referring Provider Notes:____

____

Preparation Instructions- *Abdominal Ultrasound*: 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** ____________________