ULTRASOUND

Fax to: (325) 232-7814
PHYSICIAN ORDER FORM

Patient Last Name: _____ First Name: _____DOB: _____ Sex: M F SSN: _____

Mailing Address: _____City: _____ Zip: _____ Hm Ph _____Cell Ph _____

Ordering Physician: _____ **Physician Signature:** _____ Office Ph: _____

Symptoms: _____ Date Written: _____ Office Contact: _____

Appt. Date: _____ Appt. Location: _____ Arrival Time: _____am/pm

SPECIAL INSTRUCTIONS:

☐ Stat Exam ☐ **Verbal Read, call phone #:_____** ☐ Comparison studies located _____

ULTRASOUND PROCEDURES

☐ Abdominal Aorta (76775) ☐ Abdominal Aorta Screening (G0389)	☐ Pelvic with Transvaginal (76856 + 76830)
☐ Abdomen complete (76700)	☐ Pelvic (76856)
☐ Gallbladder (76705)	☐ Transvaginal Only (76830)
☐ Liver (76705)	☐ OB Complete (76805)
☐ RUQ (76705)	☐ OB 1st Trimester (76801) ☐ Transvaginal, if needed (76817)
☐ Spleen (76705)	**Non-Vascular** ☐ Lower Extremity ☐ Upper Extremity
☐ Renal (76770)	☐ Complete Left (76881) Right (76881) ☐ Limited Left (76882) Right (76882)
☐ Soft Tissue Neck (76536)	☐ Other:_____
☐ Scrotum (76870)	**Doppler**
	☐ Abdominal Doppler (93976)
☐ Thyroid (76536)	☐ Carotids Bilateral (93380) Left (93882) Right (93882)
☐ Thoracic Outlet ☐ Bilateral (93930 + 93970) ☐ Left (93931 + 93971) ☐ Right (93931 + 93971)	☐ Upper Extremity ☐ Venous Bilateral (93970) Left (93971) Right (93971) ☐ Arterial Bilateral (93930) Left (93931) Right (93931)
☐ Lower Extremity ☐ Venous Bil (93970) Left (93971) Right (93971) ☐ Arterial Bil (93925) Left (93926) Right (93926) ☐ ABI (93922) Bil Left Right	☐ Echocardiogram (93306)
	☐ Echocardiogram Follow Up (93308)
	☐ Renal with Doppler (76770 + 93976)

****Please give at least 24 hours notice for cancellations****

Thank You for Referring Your Patients to Us

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