The Sonogram Specialist, LLC

# Ultrasound Order Form

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|---|---|
| Patient Name: | Insurance: |
| Patient Phone Number: | Policy Number: |
| DOB: | Ordering Physician: |
| Reason for exam/Diagnosis Code: | |

## Abdominal Scans

- ☐ US Abdomen Complete
- ☐ US Abdomen Limited
- ☐ US Renal
- ☐ US Bladder
- ☐ US Abd Comp w/ Doppler
- ☐ US Abd Ltd w/ Doppler
- ☐ US Renal Transplant w/ Doppler
- ☐ US Aorta

## Vascular Scans

- ☐ Lower Ext. Arterial Bilat
- ☐ Lower Ext Arterial Unilat.
- ☐ Lower Ext. Venous Bilat
- ☐ Lower Ext. Venous Unilat.
- ☐ Upper Ext. Arterial Bilat
- ☐ Upper Ext. Arterial Unilat
- ☐ Upper Ext. Venous Bilat
- ☐ Upper Ext. Venous Unilat
- ☐ Carotid Doppler
- ☐ Carotid Doppler Limited
- ☐ Transcranial Doppler
- ☐ Transcranial Doppler Ltd.
- ☐ Dialysis Access Doppler
- ☐ Dialysis Access Placement Doppler Bilateral
- ☐ Dialysis Access Placement Doppler Unilateral
- ☐ ABI only

## OB/GYN Scans

- ☐ OB 1st Trimester Complete
- ☐ OB 2/3 Trimester
- ☐ OB Limited
- ☐ OB Growth
- ☐ BPP only
- ☐ BPP + growth
- ☐ OB Transvaginal
- ☐ OB Follow up
- ☐ **Check here for multiples. # of fetus:___**
- ☐ Pelvis (Non-OB)
- ☐ Pelvis + Transvaginal
- ☐ Transvaginal (Non-OB)

## Other Scans

- ☐ US Thyroid
- ☐ US Scrotum (Doppler if needed)
- ☐ US Neonatal Head
- ☐ US Chest
- ☐ US Extremity Soft Tissue
- ☐ US Infant Hips
- ☐ US Soft Tissue Head/Neck
- ☐ _____

**Ordering Physician Signature:_____ Date:_____**

**Phone number:_____** **Facility Name:_____**

**Fax:_____**

***Please include patient demographic sheet and copy of insurance card***

**We accept most insurance plans. Self pay prices also available.**

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