



alinea
MEDICAL IMAGING

WOMEN'S ULTRASOUND

REFERRING PHYSICIAN'S OFFICE

NAME: _____

ADDRESS: _____

TEL: _____

FAX: _____

APPOINTMENTS: (909) 622-3166

Date: _____

Patient Name: _____

Date of Birth: _____ LMP: _____ Due Date: _____

PATIENT INSTRUCTIONS:

- Drink 4-6 glasses of water 1 hour before your exam. Do not empty your bladder.

INSTRUCCIONES PARA EL PACIENTE:

- Beber 4 a 6 vasos de agua, una hora antes de su ultrasonido. No vacíe su vejiga.

PHYSICIAN REFERRAL

ULTRASOUND

OBSTETRIC

- OB Complete (>14 wks)
- OB (<14 wks)
- OB Nuchal Translucency
- OB Limited
- OB Follow-up/Repeat
- Fetal Sex Only

PELVIC

- Pelvis - Transabdominal & Transvaginal
- Pelvis - Transabdominal only
- Pelvis - Transvaginal only
- Other: _____

DIAGNOSIS/INDICATION: (An appropriate diagnosis MUST BE provided.)

- 640.03** Threatened Abortion, antepartum
- 649.63** Uterine size date discrepancy, antepartum
- 655.80** Other unknown suspected fetal abnormality
- 656.53** Poor fetal growth
- 656.63** Excessive fetal growth
- V25.42, V45.51** Evaluate intrauterine device
- V28.89** Other specified antenatal scening (NT)
- _____ Other _____

Comments: _____

Provider's Full Name: _____

Provider's Signature: _____

STAT