alinea
MEDICAL IMAGING

a Rezolut partner

WOMEN'S ULTRASOUND

REFERRING PHYSICIAN'S OFFICE

NAME:
ADDRESS:
TEL:
FAX:

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

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 *(abdomen, thyroid, vascular, etc.)*

- ☐ Please specify: _____

INDICATION: (An appropriate diagnosis MUST BE provided.)

	1ST TRIMESTER	2ND TRIMESTER	3RD TRIMESTER
Uterine size date discrepancy	☐ O26.841	☐ O26.842	☐ O26.843
Placental Insufficiency	☐ O36.5110	☐ O36.5120	☐ O36.5130
Poor fetal growth	☐ O36.5910	☐ O36.5920	☐ O36.5930
Excessive fetal growth	☐ O36.61X0	☐ O36.62X0	☐ O36.63X0

Threatened Abortion	☐ O20.0
Fetal abnormality	☐ O35.8XX0
Evaluate intrauterine device	☐ Z30.431
Antenatal sceening (NT)	☐ Z36.0

Other *(please specify)*

_____

_____

Comments: _____

Provider's Full Name: _____

Provider's Signature: _____

☐ **STAT**

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