UVA Health

PLACE LABEL HERE

Ordering Date_____

MRN#_____
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DEPARTMENT OF RADIOLOGY & MEDICAL IMAGING DOWNTIME ULTRASOUND REQUEST FORM

Please **Fax to** Radiology Department

Patient Name:_____ Patient Location_____ MR#_____

Pre/Post-op Y N Date of Surgery_____ Date of_____
Test_____

DOB____/____/____ Weight:_____

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #

Referring Clinic/Office Where Report Should Be Sent	Phone N umber of Contact Person Name	Box & Fax Number

STUDY DESIRED (circle side if appropriate)

X	Study	X	Study	X	Study
	Diagnostic Abdomen		**Vascular**		**Body Procedures**
	RUQ Abdomen limited		Liver Doppler (Abd as med nec		Thoracentesis
	Abdomen Complete		Renal Artery Stenosis		Paracentesis
	Aorta / Retroperitoneal		(Renal as med necessary)		Biopsy Liver
	Renal (Native)		Upper Extremity Venous-Lt		Biopsy Thyroid
	Renal (Transplant)		Upper Extermity Venous-Rt		Biopsy Abd Mass
	Pelvic Transabd (w/EV as med ne		Upper Extremity Venous-Bilat		Biopsy Lymph Node
	Pelvic Transabdominal		Low er Extremity Venous-Lt		Aspiration
	Pelvic Endovaginal		Low er Extermity Venous-Rt		Drain Placement
	OB < 14 w eeks (w/EV as med ne		Low er Extremity Venous-Bilat		
	OB < 14 w eeks		TIPS(Abd as med necessary)		
	Thyroid/Parathyroid				

Other Study Not Listed (Specify):

Clinical Indications for Exam (Mandatory):

ICD-10 Dx Code (Mandatory):

Protocol (Internal Use Only):

ULTRASOUND IMAGING REQUEST

Physician Signature:_____

If images were taken within 2 weeks prior to scan from outside UVA please instruct pt to bring images.

Special considerations: ☐ **Non-English speaking** ☐ **Sz disorder** ☐ **Pregnancy**

Other: _____

Does Exam require early reading? ☐ **Yes** ☐ **No**

CLINICAL FORM# 030190