WESLEY Medical Center

Scheduling: 962-7900
Fax To: (833)965-0104

Last Name:	First Name:	MI:
Birthdate:	SS #:	
Phone Number (Home):	(Work):	

Appointment Time: ____ Appointment Date: ____ Check in time in Admissions: ____

PHYSICIAN ORDER FOR ULTRASOUND IMAGING

DIAGNOSIS/SYMPTOMS	CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)
		Page when results are ☐ *available* — Fax results to:

DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	Order may be modified at the discretion of the Radiologist.
	PHYSICIAN'S SIGNATURE		☐ Please notify physician if order is modified.

ULTRASOUND IMAGING

NOTE: Please circle the exam.

☐ Kidney ☐ Infant hips ☐ Thyroid ☐ Cerebral

☐ Pregnancy 1st trimester ☐ Pregnancy > 1st ☐ Pregnancy limited ☐ Biophysical profile

Carotid duplex

- ☐ Blurred vision
- ☐ Visual disturbances
- ☐ Carotid stenosis
- ☐ Carotid bruit
- ☐ TIA
- ☐ CVA
- ☐ CVD
- ☐ Syncope/presynope

☐ Right ☐ Left ☐ Bilateral

Arterial Doppler ☐ Upper ☐ Lower

- ☐ Limb pain
- ☐ Lower extremity aneurysm
- ☐ Emoblism/thrombosis
- ☐ PVD/claudication

Venous Doppler ☐ Upper extremity ☐ Lower extremity

- ☐ Limb pain
- ☐ Lower extremity aneurysm
- ☐ Lower extremity swelling
- ☐ Emoblism/thrombosis
- ☐ Edema

Abdomen

- ☐ RUQ Liver/ gallbladder
- ☐ Limited/ appy

Pelvis: non OB

- ☐ Trans-vaginal (if needed)

Pertinent Medical History:

Other:

LAB ORDERS:

☐ PT ☐ PTT

Current Lab Values: ____