KRISLAN ULTRASONIX Imaging Center

ULTRASOUND ORDER FORM

10 Ferry Street, Suite 418, Concord, NH 03301

Phone: 603-219-0204 Fax: 866-856-8908

Please fax patient insurance information separately

Patient Name:_____ Date of Birth: _____ Date: _____

Ordering Provider: _____

Phone: _____ Fax: _____

Clinical History--please include signs and symptoms: _____

_____

Diagnosis Code(s) if known: _____ _____ _____

OB/GYN: LMP: _____ EDD: _____

Exam requested but not listed below: _____

EXAMINATIONS (please check one)

OB/GYN

_____ Pelvic Non OB
*transvaginal ok if needed

_____ OB < 14 Weeks

_____ OB > 14 Weeks

_____ Fetal Survey 18-20 weeks

_____ Biophysical Profile

_____ Follicular Ultrasound

GENERAL

_____ Abdominal

_____ Abdominal Aorta

_____ Renal

_____ Scrotal

_____ Thyroid

_____ Extremity Non Vascular

VASCULAR

_____ Carotid Doppler

Leg for DVT

_____ Right _____ Left _____ Bil

Wet Reading: _____ To: _____ Hold Patient? _____

Ordering Provider Signature: _____