

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Phone#: _____

Parent name (if patient is a minor): _____

Date: _____

Ordering Provider (PRINT): _____

Ordering Providers Signature: _____

CC Provider: _____

Phone: _____

Please specify ICD-10 and narrative diagnosis:

(Do not use unspecified, rule out, probable, possible, suspected or routine)

☐ **STAT: Immediate Fax** _____

Provider number to contact for critical results: _____

Please add any additional pertinent information/ details below for radiologist and technologist.

Ultrasound General

Abdomen

- ☐ AAA - Screening
- ☐ AAA - Follow up (Includes Kidneys)
- ☐ Abdomen Complete (Liver, GB, Kidneys, Spleen)
- ☐ Abdomen Limited (RUQ - Liver, Gallbladder)
- ☐ Abdomen Limited : _____
- ☐ Elastography
- ☐ Kidney / Bladder
- ☐ Other: _____

Pelvis

- ☐ Pelvic Complete (w/ transvag if indicated)
- ☐ Pelvic Limited (Bladder only, or Appendix)
- ☐ Hysterosonogram
- ☐ Testicular w/ doppler

Obstetrics

- ☐ OB Complete: _____ weeks
- ☐ OB BPP (w/o stress)
- ☐ OB Limited / Follow up: _____

Head / Neck

- ☐ Cerebral (Infant Head)
- ☐ Soft Tissue Head / Neck
- ☐ Cervical Lymph Nodes
- ☐ Thyroid

MSK

- ☐ Infant Hips (with Bilat x-ray if needed)
- ☐ Extremity non-vascular: R / L / Bilateral
- ☐ Location: _____

Duplex Ultrasound

Abdomen

- ☐ Abdomen Duplex - Mesenteric
- ☐ Abdomen Duplex - Portal
- ☐ Abdomen Duplex - Aorta / IVC / Iliacs
- ☐ Renal Artery Duplex
- ☐ Hemodialysis Flow Study
- ☐ Other: _____

Arterial

- ☐ Ankle Brachial Index (ABI)
- ☐ Arterial Lower Extremity Duplex: R / L
- ☐ Arterial Upper Extremity Duplex: _____
- ☐ Carotid Arterial Duplex Bilateral R / L
- ☐ Temporal Artery
- ☐ Thoracic Outlet Study

Venous

- ☐ Venous Lower Extremity (DVT): R / L
- ☐ Venous Lower Extremity (Insufficiency): R / L
- ☐ Venous Mapping Lower Extremity: R / L
- ☐ Venous Upper Extremity: (DVT) R / L
- ☐ Venous Mapping Upper Extremity: R / L

Breast Imaging

Mammography

- ☐ Screening Mammogram (w/ breast ultrasound and/or biopsy if indicated)
- ☐ Diagnostic Mammogram: R / L / Bilateral (w/ US, Diagnostic follow up and/or Biopsy if indicated / Rad recommendation)

Ultrasound

- ☐ Automated Breast Ultrasound (must have current Mammo w/ dense breast diagnosis (w/ US, Diagnostic follow up and/or Biopsy if indicated / Rad recommendation)

- ☐ Breast / Axilla Ultrasound: R / L / Bilateral (with diagnostic follow up or biopsy if indicated/Rad recommendation)

- ☐ Supplemental Screening: ABUS / MRI (must meet standards of Idaho House Bill 134)

High Risk Reason _____

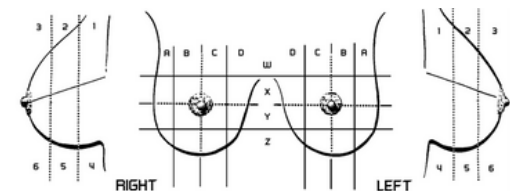
Breast Imaging Procedures

- ☐ Stereotactic Core Needle Breast Biopsy: Right / Left / Bilateral

- ☐ Stereotactic Breast Localization: Right / Left / Bilateral
Needle / Smart Clip / Both (circle one)

- ☐ Breast Ultrasound Biopsy / Aspiration: Right / Left / Bilateral

- ☐ Breast Ultrasound Localization: Right / Left / Bilateral
Needle / Smart Clip / Both (circle one)



MARK AREA OF CONCERN / CLOCK POSITION ON BREAST DIAGRAM

Clock Location: _____

Bone Density

- ☐ DEXA
- ☐ Body Composition DEXA

PLACE PATIENT STICKER HERE

