



ULTRASOUND

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax#:
Clinical History:		
Is the patient pregnant? YES NO		
Physician Signature:		Date:

ULTRASOUND

- | | |
|---|---|
| <input type="checkbox"/> Abdominal
<input type="checkbox"/> Complete
<input type="checkbox"/> Right Upper Quadrant
<input type="checkbox"/> Doppler
<input type="checkbox"/> Female Pelvis
<input type="checkbox"/> Transabdominal
<input type="checkbox"/> Transvaginal
<input type="checkbox"/> Doppler
<input type="checkbox"/> Obstetrical Sonogram:
<input type="checkbox"/> First Trimester
<input type="checkbox"/> Second or Third Trimester
<input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Aorta
<input type="checkbox"/> Kidneys
<input type="checkbox"/> Bladder
<input type="checkbox"/> Follicular
<input type="checkbox"/> Thyroid
<input type="checkbox"/> Neck (Non Thyroid)
<input type="checkbox"/> Parathyroid
<input type="checkbox"/> Popliteal Fossa <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Prostate (Transabdominal only)
<input type="checkbox"/> Scrotum |
|---|---|

Hours of Operation: Monday – Thursday 8am – 8pm
 Friday 8am – 5pm, Saturday 8am – 1pm

To schedule an appointment for an ultrasound please call 212.590.2900

Appointment Date/Time: _____

Please have your insurance card available. **Please Note:** Co payments are collected at time of visit.