



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"/> Female Pelvis <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal <input type="checkbox"/> Obstetrical Sonogram: <input type="checkbox"/> First Trimester <input type="checkbox"/> Second or Third Trimester	<input type="checkbox"/> Aorta <input type="checkbox"/> Kidneys <input type="checkbox"/> Bladder <input type="checkbox"/> Gallbladder <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 & Testes	Vascular - Doppler <input type="checkbox"/> Venous Duplex <input type="checkbox"/> Upper <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lower <input type="checkbox"/> R <input type="checkbox"/> L OTHER: _____ _____

<p>Hours of Operation: Monday - Thursday 8am – 4pm, Friday 10am – 12pm</p> <p>To schedule an appointment for an ultrasound please call 212.590.2900</p> <p>Appointment Date/Time: _____</p> <p>Please have your insurance card available. Please Note: Co payments are collected at time of visit.</p>
