blackhillsultrasound
Quality Ultrasound Imaging to Fit Your Patients, Your Practice.

PATIENT INFORMATION:

Patient Name _____Sex____ Appointment date/time_____/_____
Patient Address_____
Patient Phone Number_____ DOB _____/_____/_____ SSN _____-_____-_____

PROVIDER INFORMATION:

Ordering Provider _____ Signature _____ Date ____/_____/_____
Ordering Provider Contact Number _____ Fax/Email_____

INDICATION: _____
_____
_____

EXAMINATION INFORMATION:

- ☐ ER Read (within 30-60 min)
- ☐ Routine Read
- ☐ Call Report: _____
- ☐ Fax Report: _____
- ☐ Keep and call:_____

Please mark the exam indicated and circle upper/lower, right/left where applicable.

- ☐ Abdomen Complete
- ☐ Abdomen Complete w/Doppler
- ☐ Abdomen Limited(circle area of interest)
  RUQ LUQ RLQ LLQ
- ☐ Abdomen Limited w/Doppler
- ☐ Ankle Brachial Index (ABI)
- ☐ Aorta/Iliacs
- ☐ Arterial Duplex (circle area of interest)
  Lower ext Upper ext Right Left
- ☐ Arterial Physiologic Testing
  Segmental pressure, pulse-volume recording, doppler waveform analysis
  Lower Upper
- ☐ Biophysical Profile
- ☐ Bladder Pre and Post Void
- ☐ Carotid Duplex
  - ☐ CIMT
- ☐ Echocardiogram
- ☐ Middle Cerebral Artery (Fetal)
- ☐ OB First Trimester
- ☐ OB 2/3 Trimester
- ☐ OB 3D/4D (with measurements)
- ☐ Pelvic
- ☐ Pelvic Doppler
- ☐ Renal/Abdominal Artery Doppler
- ☐ Renal With Bladder
- ☐ Renal w/Renal Doppler
- ☐ Spinal Canal
- ☐ Testicular/Scrotum
- ☐ Thyroid
- ☐ Umbilical Artery Doppler
- ☐ Venous Duplex (circle area of interest)
  Lower ext Upper ext Right Left
- ☐ OTHER: _____
  _____
  _____

Please verify patient insurance for pre-authorization requirements and record pre-authorization number:
_____