

DEPARTMENT OF DIAGNOSTIC IMAGING
NEWPORT HOSPITAL

ULTRASOUND REQUEST FORM

TO SCHEDULE CALL - 1-866-4UR-XRAY OR FAX-401-845-4292
(1-866-487-9729)

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

MR#: _____ Phone # (Home) _____ (Work) _____

Healthcare Plan(s) _____ Number(s) _____

US EXAMS REQUESTED:

Abdomen	Pregnancy Complete	Thyroid
Aorta	Pregnancy (Multigestation)	Scrotum
GB	Biophysical Profile	Breast Right Left
Renal	Pelvis	_____

Approval for Foley Catheter if needed

VASCULAR ULTRASOUND:

Carotid	Extremities (Veins) Lower
PVR (Arterial) Lower	Extremities (Veins) Upper Right Left

REQUIRED PATIENT'S HISTORY:

Pertinent Medical/Surgical History: _____

ORDERING INFORMATION:

Date of Request: _____

Requesting Physician: _____ Attending Physician: _____

Requesting Physician's Phone or Pager #: _____

Name of Person Taking Request if ordered By Phone: _____

REQUIRED SIGNATURE OF REQUESTING PHYSICIAN: _____

Date: _____

Form #875-1244