

# ULTRASOUND ORDER FORM

PATIENT LAST NAME		FIRST		M.I.	D.O.B.	AGE	SEX
ADDRESS		PHONE NUMBER		BILL: <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> HMO/IPA <input type="checkbox"/> MEDICARE <input type="checkbox"/> PATIENT DIRECT <input type="checkbox"/> INSURANCE		DATE OF SERVICE	STAT
CITY		STATE	ZIP CODET	MEDICARE #		MEDICAL#	
ORDERING PHYSICIAN				TECHNICIAN			

## ULTRASOUND STUDIES

<input type="checkbox"/> ABDOMEN 76700		<input type="checkbox"/> RETROPERITONEUM 76770		<input type="checkbox"/> DOPPLER 93975		<input type="checkbox"/> BREAST 76645		<input type="checkbox"/> AORTA 93978	
<input type="checkbox"/> Abdominal Pain U.R.Q.	<input type="checkbox"/> Hepatomegaly	<input type="checkbox"/> Hypertensive Renal Disease		<input type="checkbox"/> Abscess		<input type="checkbox"/> Aortic Aneurysm			
<input type="checkbox"/> Abdominal Pain U.L.Q.	<input type="checkbox"/> Chronic Hepatitis	<input type="checkbox"/> Hypertrophy Of Kidney		<input type="checkbox"/> Cyst Of Breast		<input type="checkbox"/> Aortic Graft			
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Cholelithiasis	<input type="checkbox"/> Infections Of Kidney		<input type="checkbox"/> Disorders Of Breast		<input type="checkbox"/> Atherosclerosis Of Aorta			
<input type="checkbox"/> Abdominal Mass Or Lump	<input type="checkbox"/> CHOLECYSTITIS	<input type="checkbox"/> NEPHRITIS		<input type="checkbox"/> LUMP OR MASS OF BREAST		<input type="checkbox"/> DISSECTION OF AORTA			
<input type="checkbox"/> Abdominal Tenderness	<input type="checkbox"/> Calculus Of Kidney	<input type="checkbox"/> Renal Failure		<input type="checkbox"/> Mastodynia		<input type="checkbox"/> Rupture			
<input type="checkbox"/> Abdominal Colic	<input type="checkbox"/> Renal Colic	<input type="checkbox"/> Urinary Tract Infect		<input type="checkbox"/> Mastitis		<input type="checkbox"/> Thrombosis Of Aorta			
<input type="checkbox"/> Ascites	<input type="checkbox"/> Cystic Kidney Disease	<input type="checkbox"/> Cystitis		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:			
<input type="checkbox"/> Abdominal Rigidity	<input type="checkbox"/> Disorder Of Kidney	<input type="checkbox"/> Other:		<input type="checkbox"/> Thyroid 76536		<input type="checkbox"/> Prostate 76872			
<input type="checkbox"/> Elevated Liver Function test	<input type="checkbox"/> HEMATURIA			<input type="checkbox"/> HYPOTHYROIDISM		<input type="checkbox"/> ACUTE PROSTATITIS			
<input type="checkbox"/> PELVIC 76856		<input type="checkbox"/> TESTICLES 76870		<input type="checkbox"/> THYROID CYST		<input type="checkbox"/> ENLARGEMENT OF PROSTATE			
<input type="checkbox"/> Disorder Of Uterus	<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Testicular Mass		<input type="checkbox"/> Thyroid Goiter		<input type="checkbox"/> Frequent Urination			
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Pelvic Mass	<input type="checkbox"/> Testicular Pain		<input type="checkbox"/> Thyroid Mass		<input type="checkbox"/> Painful Urination			
<input type="checkbox"/> Fibrosis, Cyst Of Uterus	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Torsion		<input type="checkbox"/> Thyroiditis		<input type="checkbox"/> Prostate Pain			
<input type="checkbox"/> Inflammatory Disease Of Uterus	<input type="checkbox"/> Pelvic Swelling	<input type="checkbox"/> Varicocele		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:			
<input type="checkbox"/> Ovarian Cyst	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:							

## CARDIAC STUDIES

<input type="checkbox"/> ECHOCARDIOGRAPHY 2D & M-MODE 93306		DOPPLER		COLOR FLOW	
<input type="checkbox"/> Abnormal Ecg	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Myocardial Infarction			
<input type="checkbox"/> Aneurysm Of Heart	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Palpitation			
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Essential Hypertension	<input type="checkbox"/> Post Myocardial Infarction Syndr.			
<input type="checkbox"/> Anomalies, Ventricular	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Pulmonary Valve Disorders			
<input type="checkbox"/> Aortic Valve Disorders	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Heart Failure			
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hypertensive Heart Disease-	<input type="checkbox"/> S.O.B.			
<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Ischemic Heart Disease	<input type="checkbox"/> Tachycardia			
<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Left Ventricular Hypertrophy	<input type="checkbox"/> Other:			
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Mitral Stenosis				
<input type="checkbox"/> Cardiovascular Hypertrophy	<input type="checkbox"/> Mitral Valve Disorders				

## NON-INVASIVE VASCULAR STUDIES

<input type="checkbox"/> DUPLEX CAROTID SCAN 93880	
<input type="checkbox"/> Aneurysm Of Carotid	<input type="checkbox"/> Hypertensive Encephalopathy
<input type="checkbox"/> Aphasia	<input type="checkbox"/> Lack Of Coordination
<input type="checkbox"/> Ca Occlusion/Stenosis	<input type="checkbox"/> Speech Disturbances
<input type="checkbox"/> Carotid Bruit/Weak Pulse	<input type="checkbox"/> Syncope Or Collapse
<input type="checkbox"/> Cerebral Aneurysm	<input type="checkbox"/> Visual Field Defects
<input type="checkbox"/> Cerebral Atherosclerosis	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Cerebral Embolism	<input type="checkbox"/> Other:
<input type="checkbox"/> Disturbance Of Skin	
Sensation	

## ARTERIAL STUDIES

<input type="checkbox"/> DUPLEX SCAN OF LOWER EXTREMITY ARTERIES (BILATERAL) 93925	
<input type="checkbox"/> NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY ARTERIES 93922	
<input type="checkbox"/> UNILATERAL/ LIMITED 93926	
<input type="checkbox"/> Aneurysm Of Artery Of Upper Extremities	<input type="checkbox"/> Spasm Of Artery
<input type="checkbox"/> Arteriosclerosis Of Extremities	<input type="checkbox"/> Ulcer Of Lower Extremity
<input type="checkbox"/> Arteriosclerosis Of Lower Extremities	<input type="checkbox"/> Other:
<input type="checkbox"/> Gangrene	<input type="checkbox"/> Bone Density Measurement 76977
<input type="checkbox"/> Injury To Blood Vessels	<input type="checkbox"/> Ultrasound Bone Density Measurement
<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Pvd, Claudication (Cramping)	
<input type="checkbox"/> Rest Pain Of Lower Extremity	

## VENOUS STUDIES

<input type="checkbox"/> DUPLEX SCAN OF EXTREMITY VEINS (BILATERAL) 93970	
<input type="checkbox"/> NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY VEINS 93965	
<input type="checkbox"/> UNILATERAL/ LIMITED 93971	
<input type="checkbox"/> Anomaly Of Peripheral Vascular System	<input type="checkbox"/> Postphlebotic Syndrome
<input type="checkbox"/> Congenital Vascular Anomaly	<input type="checkbox"/> Swelling Of The Limb
<input type="checkbox"/> Edema	<input type="checkbox"/> Tachypnea
<input type="checkbox"/> Embolism Of Vein	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Gangrene	<input type="checkbox"/> Thrombosis
<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Varicose Vein With Inflammation
<input type="checkbox"/> Injury Of Blood Vessels	<input type="checkbox"/> Varicose Vein With Ulcer
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Other:

Ordering Physician Signature \_\_\_\_\_

NPI# \_\_\_\_\_