WESLEY Medical Center

Scheduling: 962-7900
Fax To: 962-7637

Last Name:	First Name:	MI:
Birthdate:	SS #:	
Phone Number (Home):	(Work):	
Appointment Time:	Appointment Date:	Check in time in Admissions:

PHYSICIAN ORDER FOR ULTRASOUND IMAGING

DIAGNOSIS/SYMPTOMS	CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)
		☐ *Page when results are available* / Fax results to:

DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	**Order may be modified at the discretion of the Radiologist.**
	PHYSICIAN'S SIGNATURE		☐ Please notify physician if order is modified.

ULTRASOUND IMAGING

NOTE: Please circle the exam.

Kidney	Infant hips	Thyroid	Cerebral

Pregnancy 1st trimester	Pregnancy > 1st	Pregnancy limited	Biophysical profile

Carotid duplex

- ☐ Blurred vision
- ☐ Visual disturbances
- ☐ Carotid stenosis
- ☐ Carotid bruit
- ☐ TIA
- ☐ CVA
- ☐ CVD
- ☐ Syncope/presynope

Right	Left	Bilateral
Arterial Doppler ☐ Upper ☐ Lower		**Venous Doppler** ☐ Upper extremity ☐ Lower extremity
☐ Limb pain ☐ Lower extremity aneurysm ☐ Emoblism/thrombosis ☐ PVD/claudication		☐ Limb pain ☐ Lower extremity aneurysm ☐ Lower extremity swelling ☐ Emoblism/thrombosis ☐ Edema

Abdomen	Pelvis: non OB
☐ RUQ Liver/ gallbladder ☐ Limited/ appy	☐ Trans-vaginal (if needed)

Pertinent Medical History:

Other:

LAB ORDERS: PT PTT

Current Lab Values: