

DEPARTMENT OF RADIOLOGY ULTRASOUND REQUEST FORM

Date ___/___/___

Patient Name _____

MR # _____ DOB ___/___/___ Age _____

Height _____ Weight _____ Gender M F

MCV CAMPUS

Main Hospital, 3rd Floor
1250 E. Marshall St., Richmond, VA 23298

Phone (804) 628-3580
FAX (804) 628-3593

Ambulatory Care Center—Basement (ACC)
417 N. 11th Street, Richmond, VA 23298

INSURANCE NAME: _____ PRE-AUTH. # _____ BILL INSURANCE? Y N

STUDY REQUESTED-DIAGNOSIS-INDICATION-REASON FOR STUDY: (print) _____

Please specify if any additional information is desired from this exam: (print) _____

ABDOMEN	ABDOMEN (cont.)	PELVIS/ SCROTAL/ TRANSVAGINAL	VASCULATURE/DOPPLER
Abdominal Aneurysm	Mass	Abscess	Abscess
Abscess	Pain	Fibroid	Baker's Cyst
Acute Renal Insufficiency	Pancreatitis	Hydrocele	Blood Clot
Ascites	Post-Trauma	Mass	Dizziness
Biliary Obstruction	Pseudocyst	Ovarian Cyst	Deep Vein Thrombosis (DVT)
Cholecystitis	Rejection	Pain	Hepatic Vein Thrombosis
Chronic Renal Insufficiency	Renal Obstruction	Swelling	Liver Transplant
Cirrhosis	Splenomegaly	Torsion	Portal Vein Thrombosis
Diabetes	UTI	OTHER	Pseudo aneurysm
Diarrhea	OTHER	HNC	Renal Artery Stenosis
Gallstones	SKELETAL	Cyst	Stenosis
Hematuria	Effusion	Goiter	Swelling
Hepatitis	Mass	Hydrocephalus	TIA
Hernia	Pain	Mass	Vessel Patency
Inc. Liver Functions (LFT)	Sacral Dimple	Pleural Effusion	OTHER
Liver Disease	OTHER	OTHER	

APPOINTMENT INFORMATION (for Radiology use ONLY)

APPOINTMENT DATE: ___/___/___ TIME: _____ AM PM LOCATION: MAIN 3 ACC

PREP INSTRUCTIONS:

_____ NPO (nothing to eat/drink) 2 4 6-8 Hours prior to exam

_____ Patient should start drinking fluids (24 oz.) 30 minutes prior to appointment time

_____ Patient should arrive 20 30 minutes prior to appointment time APPT. MADE BY: _____

Signed order required for scheduling:

Referring Physician Name _____ (print) VM # _____

Referring Physician Signature _____

Contact Name _____ Phone _____ FAX _____ DRAFT 01-09