



ULTRASOUND ORDER FORM

PATIENT LAST NAME	FIRST	M.I.	D.O.B.
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
ORDERING PHYSICIAN	MEDICARE #	MEDICAL#	

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			<input type="checkbox"/> DOPPLER COLOR FLOW		
<input type="checkbox"/> Abnormal ECG	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Aneurysm of Carotid	<input type="checkbox"/> Hypertensive	
<input type="checkbox"/> Aneurysm of Heart	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Aphasia	<input type="checkbox"/> Encephalopathy	
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Essential Hypertension	<input type="checkbox"/> Post Myocardial Infarction	<input type="checkbox"/> Ca Occlusion/Stenosis	<input type="checkbox"/> Lack of Coordination	
<input type="checkbox"/> Anomalies, Ventricular	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Syndrome	<input type="checkbox"/> Carotid Bruit/Weak Pulse	<input type="checkbox"/> Speech Disturbances	
<input type="checkbox"/> Aortic Valve Disorders	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pulmonary Valve Disorders	<input type="checkbox"/> Cerebral Aneurysm	<input type="checkbox"/> Syncope or Collapse	
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hypertensive Heart Disease-	<input type="checkbox"/> Rheumatic Heart Failure	<input type="checkbox"/> Cerebral Atherosclerosis	<input type="checkbox"/> Visual Field Defects	
<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Ischemic Heart Disease	<input type="checkbox"/> S.O.B.	<input type="checkbox"/> Cerebral Embolism	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Left Ventricular Hypertrophy	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Disturbance of Skin	<input type="checkbox"/> Other:	
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Mitral Stenosis	<input type="checkbox"/> Other:	<input type="checkbox"/> Sensation		
<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
<input type="checkbox"/> Aphasia	<input type="checkbox"/> Encephalopathy
<input type="checkbox"/> Ca Occlusion/Stenosis	<input type="checkbox"/> Lack of Coordination
<input type="checkbox"/> Carotid Bruit/Weak Pulse	<input type="checkbox"/> Speech Disturbances
<input type="checkbox"/> Cerebral Aneurysm	<input type="checkbox"/> Syncope or Collapse
<input type="checkbox"/> Cerebral Atherosclerosis	<input type="checkbox"/> Visual Field Defects
<input type="checkbox"/> Cerebral Embolism	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Disturbance of Skin	<input type="checkbox"/> Other:
<input type="checkbox"/> 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"/> Postphlebitic 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#: _____

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