



Green Country Ultrasound LLC

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ULTRASOUND REFERRAL FORM

Patient name: _____ DOB: _____

Patient phone #: _____ Patient MRN #: _____

Facility fax #: _____ Diagnosis code: _____

Indication/History: _____

GYNECOLOGICAL		ABDOMINAL	
	Pelvic- transabdominal		Abdomen complete
	Pelvic- transvaginal		RUQ (pancreas, liver, gallbladder)
	Breast- Bilateral		Abdomen limited (ascites, spleen, palp lump, etc.)
	Breast- Right		Aorta
	Breast- Left		Renal complete + bladder
OBSTETRICAL			Hernia evaluation
Use EDD of _____ OR use LMP of _____		NECK/THYROID	
			Neck (palp lump, lymphadenopathy, etc.)
			Thyroid
☐ Anatomy ☐ Biophysical Profile ☐ Growth/dating ultrasound ☐ Follow-Up (AFI, cervix, placenta, etc.) ☐ OB fetal MCA Doppler ☐ OB umbilical artery Doppler ☐ OB transvaginal ☐ OB 1st trimester < 14 weeks		OTHER	
			Chest (pleural effusion, palp lump, etc.)
			Groin (hernia, lymph nodes, etc.)
			Testicular/scrotal
			Other (please explain at top of form)
			Non-vasc extremity (specify region at top of form)
		VASCULAR	
			Liver Doppler
SPECIALITY PEDIATRICS			Renal Doppler
	Infant pylorus		Lower extremity venous Doppler
	Infant spine		Mesenteric Doppler
	Infant hips		Carotid Duplex- bilateral
	Appendix		

Provider (printed): _____

Provider (signature): _____

Date: _____