WhidbeyHealth Medical Center
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Ultrasound Requisition

Date and Time of exam: _____ MRN: _____

Patient Data | **Procedure Information**

_____
Last Name First Name MI
DOB: _____
Telephone: _____

Date of Injury/Onset: _____
- ☐ **STAT**
- ☐ **Routine**
- ☐ **Call Back Phone #**:_____

Diagnosis/Signs/Symptoms to indicate reason for the procedure: _____

_____

_____

- ☐ Abdomen Complete
  - ☐ Add Doppler MPV
- ☐ Abdomen Limited
  - ☐ Specific area of interest _____
  - ☐ RUQ (Gallbladder/CBD/Liver/Rt Kidney)
    - ☐ Add Doppler MPV
- ☐ Ankle Brachial Indices (ABIs)
- ☐ Aorta
  - ☐ Doppler if Indicated
- ☐ Appendix
- ☐ Bladder
- ☐ Carotid Doppler
- ☐ Hernia (Location: _____)
- ☐ Mesenteric Artery Doppler
- ☐ Pelvis with Transvaginal
  - ☐ Doppler if indicated
- ☐ Pelvis, Transabdominal only
  - ☐ Doppler if indicated
- ☐ Kidneys & Bladder
  - ☐ Add Doppler Resistive Indices
- ☐ Renal Artery Doppler
- ☐ Scrotum
  - ☐ Doppler if indicated
- ☐ Thyroid
- ☐ Other: _____

Interventional Ultrasound: _____

Ultrasound Extremities

☐ Venous Doppler Extremity
- ☐ Lower Extremity ☐ Right ☐ Left ☐ Bilateral
- ☐ Upper Extremity ☐ Right ☐ Left ☐ Bilateral

☐ Arterial Doppler Extremity
- ☐ Lower Extremity ☐ Right ☐ Left ☐ Bilateral
- ☐ Upper Extremity ☐ Right ☐ Left ☐ Bilateral

Obstetrics: LMP_____ **EDC** _____
- ☐ BPP
- ☐ 1st Trimester
  - ☐ OB Transvaginal
- ☐ 2nd/3rd Trimester Follow up
- ☐ 2nd Trimester Anatomy Screen
  - ☐ Additional images as indicated
- ☐ OB Limited (i.e. AFI, etc. _____)

Provider Signature: _____ **Date/time:** _____

Printed Name of Ordering Provider: _____