Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

OBSTETRICAL ULTRASOUND REQUEST

Please complete and fax to **(603)-640-1944**
For telephone assistance: **(603)-650-7451**

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Special Considerations: MRN:_____

- ☐ Blind
- ☐ Deaf
- ☐ Diabetic
- ☐ Disoriented
- ☐ IV
- ☐ O^2
- ☐ Pregnant
- ☐ **Precautions**
- ☐ Stretcher Needed
- ☐ Wheelchair Needed

Notes: _____

INDICATION / REQUEST DETAILS (*Required)

Reason for Exam*: _____

ICD 10 Code*: _____ **Code Description*:** _____

Other Pertinent Information: _____

Dating (Please check dating criteria below):

- ☐ EDD (estimated delivery date) not established
- ☐ Established EDD: _____/_____/_____
- ☐ Last Menstrual Period (LMP): _____/_____/_____

Basis of EDD (estimated delivery date):

- ☐ LMP
- ☐ LMP & Ultrasound
- ☐ Ultrasound Only
- ☐ Other

Study Desired (Please Check)*:

- ☐ OBS Screening Morphology - 76805
- ☐ MFM Genetics – High Risk – 76811
- ☐ MCA Doppler - 76821
- ☐ UA Doppler – 76820
- ☐ Ob Limited – 76815
- ☐ Ob Nuchal Translucency – 76813 / 76814
- ☐ Ob Transvaginal – 76817
- ☐ Ob Cervical Length – 76817
- ☐ Biophysical Profile – 76819

Multiple Gestation

- ☐ Twins - 76811 ☐ Triplets - 76812
- ☐ Other _____

Growth:

- ☐ EFW / Growth - 76818
- ☐ Re-evaluation / Abnormality Follow-up - 76815
- ☐ Growth Multiple Gestation - 76816

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____

Ordering Provider Name (Print): _____

- ☐ Staff Physician
- ☐ Resident/Other

Ordering Provider Signature*: _____ Date: _____/_____/_____

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