

Referral Form Obstetrical Ultrasound

Today's Date: _____ Appointment Date: _____ Appointment Time: _____

Patient Name: _____

MRN: _____ DOB: _____

Mailing address: _____

Home phone: _____ Other: _____

Requesting Provider: _____

Office phone: _____ Pager #: _____

Address: _____

History/ Questions to be answered (all indications must be listed): _____

Dating (please check dating criteria below):

- EDD not established
- Established EDD: _____
- LMP: _____

Basis of EDD (please check):

- LMP
- LMP and US
- US only
- Other

Outside Ultrasound reports must accompany this requisition.

Study desired (please check):

OBS – MFM (uobs – 76805; umfm – 76811)

- Screening morphology
- Genetics – high risk

Growth (uobfol – 76816)

- EFW / Growth
- Re-evaluation / Abnormality follow-up

Ob Limited (uoblilim – 76815)

- AFI
- Position

Ob – NT (unt – 76813 / 76814)

- Nuchal translucency (11.2 – 13.9 wks)
(separate FBR requisition required)

Storage Only (sousbp) – Fax to: (603) 653-6147

- Storage only

Amniocentesis (uamnio – 76946)

- Genetic amniocentesis (76946)
- Isoimmunization
- Lung maturity (76946)
- Therapeutic amniocentesis

Multiple Gestation (uobmul – 76805, 76810)

- Twins
- Triplets
- Other: _____

Transvaginal (obtv – 76817)

- Cervical length
- Viability / Dating \leq 14 weeks

Biophysical Profile (ubpp – 76818)

- BPP

Doppler Studies

- MCA Doppler (uobmca – 76821)
- UA Doppler (uobua – 76820)

Provider Signature: _____