

## Referral Form Pelvic Ultrasound

Today's Date: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Other: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_

Office phone: \_\_\_\_\_ Pager #: \_\_\_\_\_

Address: \_\_\_\_\_

Exam History / Questions to be answered (all indications must be listed): \_\_\_\_\_

**Study desired (please check):**

**\* Indicates additional information below is required.**

- \*  Transvaginal ( utv )  
(will be performed unless contraindicated)
- OI ( uoi ) \_\_\_\_\_ Baseline \_\_\_\_\_ Day
- \*  SHG ( ushg )
- Mock transfer ( met )
- IVF Harvest ( uivftv )

- \*  Transabdominal ( upel )
- Transabdominal guidance in OR ( upel / usp )  
(pre-approval required)
- Cyst aspiration ( ucyst )
- Embryo transfer ( uembry )

Person providing the following information: \_\_\_\_\_

(please print)

\* LMP: \_\_\_\_\_

- \* Peri-menopausal  Yes  No
- \* Post-menopausal  Yes  No
- \* Pelvic pain  Yes  No
- \* On hormones  Yes  No
- \* On Tamoxifen  Yes  No
- \* Previous children  Yes  No
- \* Previous pelvic surgeries  Yes  No

**History of:**

- \* Abnormal bleeding  Yes  No
- \* Endometriosis  Yes  No
- \* Pelvic infections  Yes  No
- \* Ectopic pregnancy  Yes  No
- \* Tubes tied  Yes  No

If yes, please describe: \_\_\_\_\_

Provider Signature: \_\_\_\_\_