Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

PELVIC 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: _____

Study Desired*:

☐ Transvaginal ☐ Ovulation Induction / Antral Follicle Count ☐ Transabdominal (DH Sonographer approval required)

Date of Last Menstrual Period*: (MM/DD/YYYY): _____/_____/_____

History Of:

Abnormal Bleeding*	☐ Yes ☐ No	Pelvic Pain*	☐ Yes ☐ No
Ectopic Pregnancy*	☐ Yes ☐ No	Peri-menopausal*	☐ Yes ☐ No
Endometriosis*	☐ Yes ☐ No	Post-menopausal*	☐ Yes ☐ No
On hormones*	☐ Yes ☐ No	Previous Children*	☐ Yes ☐ No
On Tamoxifen*	☐ Yes ☐ No	Previous Pelvic Surgeries*	☐ Yes ☐ No
Pelvic Infections*	☐ Yes ☐ No	Tubes Tied*	☐ Yes ☐ No

If yes, please describe: _____
_____

REFERRING PROVIDER

Ordering Facility Name: _____

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

Ordering Provider Name (Print): _____

Ordering Provider Signature*: _____

☐ Staff Physician
☐ Resident/Other

Date: _____/_____/_____

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