

STRONG HEALTH

HIGHLAND HOSPITAL

**RADIOLOGIC CONSULTATION
HH 520H MR**

**ULTRASOUND
EXAMINATION**

- Inpatient
- Outpatient
- ED
- ICU

NAME
MEDICAL RECORD #:
BIRTHDATE
PCP:

AREA TO BE EXAMINED / TYPE OF EXAMINATION		SCHEDULED DATE:	FOR EMERGENCY CONSULTATIONS AFTER 4 PM MON. - FRI., SATURDAY, SUNDAY AND HOLIDAYS, FAX TO STRONG MEMORIAL RADIOLOGY (585) 506-0062
		FLOOR	
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) <i>Rule out diagnosis not acceptable</i>		SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ MD	
		FIRST _____ LAST _____	
		ADDRESS _____	
		STREET _____ CITY _____ ZIP _____	
HISTORY / CLINICAL INFORMATION (REQUIRED)		CLINICIAN SIGNATURE ATTENDING/RESIDENT/NP/PA _____ RESIDENT _____ BEEPER _____	
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP		FOR URGENT / EMERGENCY RESULTS MON. - FRI. AFTER 5 PM & WEEKENDS, PLEASE INCLUDE FAX #.	
BUN	Creatinine	PRECAUTIONS	
		FAX #:	

ULTRASOUND

The following exams may be requested with this form:

- | | |
|--|---|
| BREAST IMAGING | CHEST DIRECTED |
| TOTAL ABDOMINAL (SEARCH) | BRAIN COMPLETE |
| UPPER ABDOMINAL (COMPLETE DIRECTED) | THYROID/PARATHYROID |
| RETROPERITONEAL IMAGING (RENAL, AORTIC) COMPLETE | SCROTAL |
| TOTAL ABDOMEN (DIRECTED INC. PELVIS) | EXTREMITIES |
| RENAL BIOPSY: LOCALIZATION | CAROTID AND PERIPHERAL VASCULAR IMAGING |
| PELVIC COMPLETE | PORTABLE ABDOMINAL |
| O.B. COMPLETE | TRANSRECTAL |
| THORACENTESIS | THORACIC OUTLET |
| CYST/ABSCESS ASPIRATION | |
| NEEDLE BIOPSY | |

All ultrasound exams must be scheduled.
Scheduling, Reports or Film Requests: (585) 341-6785

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