

**ULTRASOUND EXAMINATION**

- INPATIENT
- OPD
- ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

AREA TO BE EXAMINED / TYPE OF EXAMINATION	TODAY'S DATE:	SEND PHYSICIAN'S PERSONAL COPY TO:		
	FLOOR/CLINIC	NAME: _____ M.D.		
DIAGNOSIS OR CLINICAL SUSPICION <b>(REQUIRED)</b> <i>Rule out diagnosis not acceptable</i>	WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/>	FIRST _____ LAST _____ ADDRESS _____ STREET _____ CITY _____ ZIP _____		
	<b>ICD-9 CODES</b>	<b>PHYSICIAN'S SIGNATURE</b> ATTENDING _____ RESIDENT _____ BEEPER _____		
HISTORY / CLINICAL INFORMATION <b>(REQUIRED)</b>	SCHEDULED FOR _____ <input type="checkbox"/> AM _____ <input type="checkbox"/> PM			
	DATE _____ HOUR _____			
	ARRIVED _____	COMPLETED _____		
	ROOM _____	TECHNOLOGIST _____	8 X 10 _____	
	QUALITY CONTROL _____		POLAROID _____ 35 mm _____	
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP _____		ADDITIONAL INFORMATION		
BUN _____ mg%	BILIRUBIN _____ mg%	RBC _____		
CAUTIONS/RISKS				

**ULTRASOUND**

**The following exams may be requested with this form**

BREAST IMAGING  
 TOTAL ABDOMINAL (SEARCH)  
 UPPER ABDOMINAL (COMPLETE DIRECTED)  
 RETROPERITONEAL IMAGING (RENAL, AORTIC) COMPLETE  
 TOTAL ABDOMEN (DIRECT INC. PELVIS)  
 RENAL BIOPSY: LOCALIZATION  
 PELVIC COMPLETE  
 O.B. COMPLETE  
 THORACENTESIS  
 CYST/ABSCESS ASPIRATION  
 NEEDLE BIOPSY

CHEST DIRECTED  
 BRAIN COMPLETE  
 THYROID/PARATHYROID  
 SCROTAL  
 EXTREMITIES  
 CAROTID AND PERIPHERAL VASCULAR IMAGING  
 PORTABLE ABDOMINAL  
 TRANSRECTAL  
 THORACIC OUTLET  
 O.P.G.

**All ultrasound exams must be scheduled.**  
 Scheduling, Report or Film Requests: (585) 275-8216/17

**Mailing Address: Strong Memorial Hospital  
 Department of Radiology, Box 648  
 Rochester, NY 14642-8648**

NOTE: ABDOMINAL & PELVIC ULTRASOUND EXAMS REQUIRE PREP  
 CALL (585) 275-8216/17 FOR INSTRUCTIONS