MUNSON HEALTHCARE

OUTPATIENT ULTRASOUND ORDER FORM

Please mark facility where test is scheduled

SCHEDULING (for facilities listed below): Phone: 800-968-9292 Fax: 231-935-3473

- ☐ KALKASKA MEMORIAL HEALTH CENTER
- ☐ MUNSON COMMUNITY HEALTH CENTER
- ☐ MUNSON HEALTHCARE CADILLAC HOSPITAL
- ☐ MUNSON HEALTHCARE GRAYLING HOSPITAL
- ☐ MUNSON MEDICAL CENTER (Main Lobby)
- ☐ PAUL OLIVER MEMORIAL HOSPITAL
- ☐ MUNSON HEALTHCARE CHARLEVOIX HOSPITAL
  Scheduling: 231-547-8801 Fax: 231-935-7878
- ☐ MUNSON HEALTHCARE MANISTEE HOSPITAL
  Scheduling: 231-398-1114 Fax: 231-398-1408

PATIENT LEGAL NAME	DOB	TEST DATE	TEST TIME

CLINICAL INDICATIONS:

Complete and specific *clinical information* is necessary for the Radiologist to supervise the scanning of each patient, as well as a requirement of insurance companies. Exams without pertinent clinical information may be delayed and/or rescheduled.

CALL REPORT TO:	COPY REPORT TO:	❒ PHONE ❒ PAGER ❒ FAX Number:

❒ HOLD PATIENT ❒ CD TO GO ❒ DICTATE PRIOR TO APPOINTMENT ON: AT:

******ALL ITEMS IN RED HAVE A PREP WHICH IS LISTED ON THE REVERSE SIDE******

ABDOMEN
- ❒ US ABDOMEN RUQ
- ❒ US ABDOMEN LUQ
- ❒ US ABDOMEN COMPLETE
  (includes panc, gb, liver, biliary tree, spleen, and limited views of aorta, ivc and kidneys)
- ❒ US ABDOMEN APPENDIX
  (if female pt and want ut and ov's also order transvaginal)
- ❒ US ABDOMEN HERNIA - specific area:_____
- ❒ US ABDOMEN ASCITES
  (includes ascites check only no organs)
- ❒ US AORTA ABDOMINAL
- ❒ US AORTA/RENAL COMPLETE
  (full aorta and kidney ultrasound)
- ❒ US AORTA SCREENING
  (Medicare patients only-see qualificatons)
- ❒ US INGUINAL HERNIA
  ☐ L ☐ R
- ❒ US RENAL
- ❒ US RENAL/BLADDER
- ❒ US BLADDER

PELVIS
- ❒ US TRANSVAGINAL NON-OB
- ❒ US PELVIS
  (only patients who cannot have transvaginal)
- ❒ US FOLLICULAR
- ❒ US TESTICULAR/SCROTUM

US BREAST
- ❒ Must be scheduled with mammography scheduler

US OB
- ❒ US OB 1st TRIMESTER
  ❒ Twins ❒ Triplets ❒ Quads
  ❒ EDD_____
  ❒ Unknown*
- ❒ US OB COMPLETE - first exam 14 wks or more
  ❒ Twins ❒ Triplets ❒ Quads
  ❒ EDD_____
  ❒ Unknown*

US OB - continued
- ❒ US OB FOLLOW-UP
  ❒ Twins ❒ Triplets ❒ Quads
  ❒ EDD_____
  ❒ WITH CORD DOPPLER
- ❒ US OB FETAL ECHO - *must be 22 weeks*
- ❒ US OB LIMITED - Does not include **ANY** fetal Biometry
  Check any or all that apply:
  ❒ AFI ONLY ❒ CORD DOPPLER
  ❒ FETAL HEART TONES ONLY
  ❒ FETAL POSITION ONLY
  ❒ PLACENTA POSITION ONLY
- ❒ US OB BIOPHYSICAL PROFILE

HEAD/NECK/SOFT TISSUE
- ❒ US THYROID
- ❒ US NECK SOFT TISSUE
  specify area:_____
- ❒ US HEAD SOFT TISSUE
  specify area:_____
- ❒ US TRUNK/ABDOMEN SOFT TISSUE
  specify area:_____
- ❒ US EXTREMITY NON-VASCULAR
  ☐ L ☐ R
  specify area:_____

MUSCLE/TENDON
- ❒ US SHOULDER ☐ L ☐ R
- ❒ US EXTR NON-VASCULAR TENDON/MUSCLE
  ☐ L ☐ R
  specify area:_____

US PEDIATRICS
- ❒ US CRANIAL NEONATAL
- ❒ US HIPS INFANT - Age requirement_____
- ❒ US ABDOMEN RUQ
- ❒ US ABDOMEN LUQ
- ❒ US ABDOMEN COMPLETE (includes panc, gb, liver, biliary tree, spleen & limited views of aorta, ivvc & kidneys)
- ❒ US RENAL BLADDER
- ❒ US SPINE AND CONTENTS
- ❒ US EXT NON-VASC
  ☐ L ☐ R
  specify area:_____

PROCEDURES
- ❒ US GUIDED THORACENTESIS ☐ L ☐ R
  Specify labs for fluid:_____
  ☐ No labs
- ❒ US GUIDED PARACENTESIS ☐ L ☐ R
  Specify labs for fluid:_____
  ☐ No labs
- ❒ US GUIDED THYROID FNA
- ❒ US GUIDED THYROID CYST ASPIRATION
- ❒ US GUIDED PROSTATE BIOPSY PSA level_____
- ❒ US GUIDED PROSTATE BIOPSY with Sedation
  PSA level_____
- ❒ US GUIDED GOLD SEED PROSTATE
- ❒ US GUIDED GOLD SEED RECTAL WALL
- ❒ US GUIDED LIVER BIOPSY -
  need consultation w/radiologist
- ❒ US GUIDED HYSTEROSONOGRAM
- ❒ US GUIDED HIP JOINT ASP/INJ
  specify side:_____
- ❒ US GUIDED KNEE JOINT ASP/INJ
  specify side:_____
- ❒ US GUIDED HIP TENDON INJECTION
  specify side:_____
- ❒ US GUIDED FINE NEEDLE ASPIRATION
  Need consultation with Radiologist
  specify area:_____
- ❒ US GUIDED PSEUDOANEURYSM INJECTION

PATIENT ID LABEL

Ordering Provider (Print)

Provider Signature **Date** **Time**

Patient Name:_____ Date:_____

VASCULAR LAB

❒ **USV CAROTID**
(includes vertebral and subclavian arteries)

ABDOMINAL DOPPLER
❒ USV RENAL ARTERY DOPPLER
❒ USV MESENTERIC DOPPLER
❒ USV LIVER DOPPLER
❒ USV LIVER DOPPLER W/TIPPS
❒ USV INFERIOR VENA CAVA
❒ USV RENAL VEIN
❒ USV SPLENIC VEIN
❒ USV KIDNEY TRANSPLANT

EXTREMITIES
❒ USV LOWER ARTERIAL W/ABI EXERCISE
❒ USV UPPER ARTERIAL W/ABI EXERCISE
☐ Technologist will determine if exercise is appropriate for exam
❒ USV PALMER ARCH
❒ USV LOWER EXT VEIN
(cannot use r/o dvt for diagnosis)
☐ BILAT ☐ L ☐ R
❒ USV UPPER EXT VEIN
(cannot use r/o dvt for diagnosis)
☐ BILAT ☐ L ☐ R
❒ USV CALF REFLUX STUDY
☐ BILAT ☐ L ☐ R
❒ USV UPPER EXT ARTERY
(duplex scan)
☐ BILAT ☐ L ☐ R
❒ USV LOWER EXT ARTERY
(duplex scan)
☐ BILAT ☐ L ☐ R

EXTREMITIES-continued
❒ USV VEIN MAPPING LEG
☐ BILAT ☐ L ☐ R
❒ USV VEIN MAPPING ARM
☐ BILAT ☐ L ☐ R
❒ USV VEIN MAPPING HEMODIALYSIS ACCESS
❒ USV GROIN PSEUDO
☐ BILAT ☐ L ☐ R

BYPASS/ GRAFTS/FISTULA
❒ USV DIALYSIS GRAFT
❒ USV DIALYSIS FISTULA
❒ USV BYPASS GRAFTS
specify type:_____
specify location:_____
☐ BILAT ☐ L ☐ R

YOU MUST FAX BOTH SIDES OF FORM

PREPS

ULTRASOUND PREPS

ABDOMEN RUQ AND COMPLETE
Patient should have nothing to eat or drink for at least 6 hours prior to exam time

RENAL/BLADDER
***ALL PTS UNDER 16 YRS OF AGE**
Patient should have a full bladder
Drink 16-20oz of fluid 1 hour prior to exam

PELVIS
**** for patients who cannot have a vaginal ultrasound****
Patient should have a full bladder
Drink 16-20oz of fluid 1 hour prior to exam

PROSTATE BIOPSY
Cleansing enema 1-2 hours before exam
You may eat lightly prior to exam
Radiology nurse will be calling prior to the exam

VASCULAR LAB PREPS

RENAL ARTERY AND MESENTERIC ARTERY PREP
Do not eat foods that cause a gassy stomach (beans, spicy foods, carbonated or alcoholic beverages, etc.)
Take maximum strength Mylanta Gas Tablets or similar non-prescription simethicone product, 1 tablet every 6 hours the day before the exam and 1 tablet the day of the exam. No food after 6:00pm the night before the exam.
Continue to take prescribed medications with water only.