Name : **MR#:** **DOB:** **Phone #:** (Patient Identification)	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Ultrasound Request Form**

Scheduling Phone: 804-828-6359 **Scheduling Fax: 804-828-5570**

Requesting ATTENDING Provider/Clinical Service: _____

Contact Nurse Practitioner/Registered Nurse for questions (Phone/Pager #): _____

Diagnosis/Indication: _____ ICD-9 Code (required): _____

PLEASE SELECT THE SPECIFIC BODY LOCATION OR TYPE OF ULTRASOUND STUDY

	ABDOMEN		**ABDOMEN**		**HEAD, NECK & CHEST**		**SKELETAL**
	Abdomen- Complete		Kidney Vasculture		Chest (pleura)		Extremity
	Abdomen- RUQ		Liver Only		Chest Soft Tissue		Hip
	Abdomen – Soft Tissue (limited study; hernia/ascites)		Liver Vasculature		Head		Spine
	Abdomen Vessel		Pancreas Transplant		Thyroid & Neck		**PELVIS**
	Aorta		Renal, Bladder		Transcranial Doppler		Pelvis (including reproductive organs)
	Gallbladder only		Spleen				Scrotal
	Kidney Transplant						Transvaginal

Other Ultrasound Study Requests: _____ _____ _____	**Provider Printed Name & Signature:** (Note: Federal regulations require a provider's signature) Provider Signature _____ Provider Printed Name _____ Provider Pager _____ Date _____ Office/Location Code _____

Appointment Information (Radiology Use Only)

Unable to Schedule: ☐ Specific Date/Time Unavailable ☐ Order incomplete/resubmit Faxed_____

Appt Date: _____ Appt Time: _____ Location: ACC Main 3 Main –PEDS 3 Stony Point

PREP INSTRUCTIONS:

_____ NPO (nothing to eat/drink) 2 4 8 hours prior to appt time _____ Pt should arrive: 20 30 minutes prior to appt time

_____ Pt should start drinking fluids (24oz) 15 30 minutes prior to appt time

IMN_____ CERNER_____ MCK_____ Conf'd w/ PT_____ APPT MADE BY: _____