ADVANCE ULTRASOUNDS

ULTRASOUND REQUEST FORM

P O BOX - 1032, PLAINFIELD , IL 60544-1032
Ph - 630-470-9813 Fax- 708-887-5522
Website : aul.care

PATIENT NAME:_____PH#_____

PATIENT DOB:_____ADDRESS:_____

CITY:_____ ZIP:_____

INSURANCE NAME:_____GROUP #:_____

CARDHOLDER DOB:_____ID#:_____SEX:_____

PLEASE CHECK SERVICE(S) TO BE PERFORMED

☑ ARTERIAL DOPPLER (LE)	☑ VENOUS DOPPLER (LE)
INDICATIONS	INDICATIONS
☐ Abnormalities Lower Limb ☐ Arterial Occlusive Disease ☐ Arterial Thrombosis ☐ Atherosclerosis ☐ Calf/Thigh Pain ☐ Discoloration of Skin ☐ Intermittent Claudication ☐ Leg Cramps ☐ Numbness ☐ Peripheral Vascular Disease ☐ Swelling of Limb ☐ Ulceration ☐ Weak Pulse on Feet	☐ Calf / Thigh Pain ☐ Deep Vein Thrombosis ☐ Leg Edema ☐ Numbness ☐ Pain in the Limb ☐ Phlebitis ☐ Ulceration ☐ Varicose Veins ☐ Venous Insufficiency ☐ Venous Thrombosis

DIAGNOSIS (OTHER) _____

DATE OF APPOINTMENT:_____

TIME:_____

PHYSICIAN SIGNATURE:_____

DATE:_____