ULTRASOUND REQUEST FORM

P O BOX - 1032, PLAINFIELD , IL 60544-1032
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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)** **DX:**___________________________
- **VENOUS DOPPLER (LE)** **DX:**___________________________
- **ABDOMINAL: COMPLETE ULTRASOUND** **DX:**___________________________
- **AAA SCREENING** **DX:**___________________________
- **CAROTID DOPPLER** **DX:**___________________________
- **PELVIC ULTRASOUND** **DX:**___________________________
- **PROSTATE ULTRASOUND** **DX:**___________________________
- **THYROID ULTRASOUND** **DX:**___________________________
- **BREAST ULTRASOUND** **DX:**___________________________
- **OTHER:** ____

DATE OF APPOINTMENT & TIME: ____

PHYSICIAN SIGNATURE: ____ **DATE:** ______________