2921 Brown Trail Road, Ste. 150
Bedford, Texas 76021
817-849-8700 Fax 817-849-8701

Referral for Ultrasound

Patient Name: _____

Date of Birth: _____ Phone #: _____

Referring Provider: _____

Referring Provider Phone/FAX: _____

Examination Requested

Obstetrics/Gynecology	Abdomen/Small Parts	Cardiac and Vascular
☐ 1st Trimester	☐ Abdomen (GB/Liver, etc)	☐ Diagnostic Echocardiogram
☐ 2nd Trimester	☐ Renal	☐ Screening Echo/EKG (asymptomatic only)
☐ 3rd Trimester	☐ Aorta	☐ Carotid Duplex
☐ Biophysical Profile	☐ Thyroid	☐ Venous Duplex (LE)
☐ Pelvis	☐ Scrotum	☐ Arterial Duplex (LE)
☐ Other _____	☐ Other _____	☐ Other _____

Reason for exam (symptoms/diagnosis): _____

_____

Special Instructions: _____

_____

_____
Provider Signature

Send report: ☐with patient ☐by fax ☐by mail ☐e-mail to: _____