Ultrasound / Mammography

Kootenai Outpatient Imaging

PATIENT INFORMATION

Patient Name:_____DOB:_____

Phone#:_____

Parent name (if patient is a minor):_____

Please specify ICD-10 and narrative diagnosis:
(Do not use unspecified, rule out, probable, possible, suspected or routine)

REFERRING PROVIDER

Date:_____

Ordering Provider (PRINT):_____

Ordering Providers Signature:_____

CC Provider: _____

Phone: _____

☐ STAT: Immediate Fax_____

Provider number to contact for critical results:

_____

Please add any additional pertinent information/ details below for radiologist and technologist.

_____

_____

Ultrasound General

Abdomen
- ☐ AAA - Screening
- ☐ AAA - Follow up (Includes Kidneys)
- ☐ Abdomen Complete (Liver, GB, Kidneys, Spleen)
- ☐ Abdomen Limited (RUQ - Liver, Gallbladder)
- ☐ Abdomen Limited : _____
- ☐ Elastography
- ☐ Kidney / Bladder
- ☐ Other: _____

Pelvis
- ☐ Pelvic Complete (w/ transvag if indicated)
- ☐ Pelvic Limited (Bladder only, or Appendix)
- ☐ Hysterosonogram
- ☐ Testicular w/ doppler

Obstetrics
- ☐ OB Complete: _____ weeks
- ☐ OB BPP (w/o stress)
- ☐ OB Limited / Follow up:_____

Head / Neck
- ☐ Cerebral (Infant Head)
- ☐ Soft Tissue Head / Neck
- ☐ Cervical Lymph Nodes
- ☐ Thyroid

MSK
- ☐ Infant Hips (with Bilat x-ray if needed)
- ☐ Extremity non-vascular: R / L / Bilateral
- ☐ Location: _____

Duplex Ultrasound

Abdomen
- ☐ Abdomen Duplex - Mesenteric
- ☐ Abdomen Duplex - Portal
- ☐ Abdomen Duplex - Aorta / IVC / Iliacs
- ☐ Renal Artery Duplex
- ☐ Hemodialysis Flow Study

☐ Other:_____

Arterial
- ☐ Ankle Brachial Index (ABI)
- ☐ Arterial Lower Extremity Duplex: R / L
- ☐ Arterial Upper Extremity Duplex:
- ☐ Carotid Arterial Duplex Bilateral R / L
- ☐ Temporal Artery
- ☐ Thoracic Outlet Study

Venous
- ☐ Venous Lower Extremity **(DVT)**: R / L
- ☐ Venous Lower Extremity (Insufficiency): R / L
- ☐ Venous **Mapping** Lower Extremity: R / L
- ☐ Venous Upper Extremity: **(DVT)** R / L
- ☐ Venous **Mapping** Upper Extremity: R / L

Breast Imaging

Mammography
☐ Screening Mammogram
(w/ breast ultrasound and/or biopsy if indicated)

☐ Diagnostic Mammogram: R / L / Bilateral
(w/ US, Diagnostic follow up and/or Biopsy if indicated / Rad recommendation)

Ultrasound
☐ Automated Breast Ultrasound
(must have current Mammo w/ dense breast diagnosis)

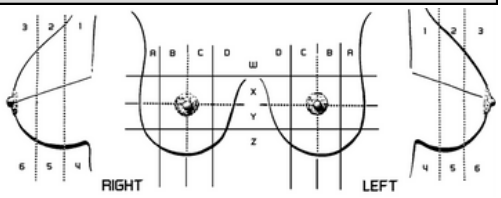
☐ Breast / Axilla Ultrasound: R / L / Bilateral
(with diagnostic follow up or biopsy if indicated/Rad recommendation)

Breast Imaging Procedures
☐ Stereotactic Core Needle Breast Biopsy:
Right / Left / Bilateral

☐ Stereotactic Breast Localization:
Right / Left / Bilateral
Needle / Smart Clip / Both (circle one)

☐ Breast Ultrasound Biopsy / Aspiration:
Right / Left / Bilateral

☐ Breast Ultrasound Localization:
Right / Left / Bilateral
Needle / Smart Clip / Both (circle one)



MARK AREA OF CONCERN / CLOCK POSITION ON BREAST DIAGRAM

Clock Location:

_____

Bone Density
- ☐ DEXA
- ☐ Body Composition DEXA

PLACE PATIENT STICKER HERE

KootenaiHealth

To schedule please call | T: 208-625-6300 | F: 208-625-6301 | M-F 7am-5:30pm

Referral Attachment