Dartmouth-Hitchcock
MEDICAL CENTER

Department of Radiology
Scheduling: (603) 650 - 7451
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Referral Form
Obstetrical Ultrasound

Today's Date: _____ Appointment Date: _____ Appointment Time: _____

Patient Name: _____

MRN: _____ DOB: _____

Mailing Address: _____

Home Phone: _____ Other: _____

Requesting Provider: _____

Office Phone: _____ Pager #s: _____

Address: _____

Exam History / Questions to be answered (all indications must be listed):

_____

ICD10 code: _____

Dating (please check dating criteria below)

- ☐ EDD not established
- ☐ Established EDD: _____
- ☐ LMP: _____

Basis of EDD (please check):

- ☐ LMP ☐ LMP and US
- ☐ US only ☐ Other

Outside Ultrasound reports must accompany this requisition.

Study desired (please check):

OBS – MFM (uobs – 76805; umfm – 76811)

- ☐ Screening morphology
- ☐ Genetics – High Risk

Ob Limited (uoblim – 76815)

- ☐ AFI
- ☐ Position

Multiple Gestation (umfm multi – 76811, 76812)

- ☐ Twins ☐ Triplets
- ☐ Other: _____

Ob – NT (unt – 76813 / 76814

- ☐ Nuchal translucency

Growth

- ☐ EFW / Growth (uobfol – 76818)
- ☐ Re-evaluation / Abnormality follow-up (uobmorph – 76815)
- ☐ Growth multiple gestation (uobfolmult – 76816)

Transvaginal (obtv – 76817)

- ☐ Cervical length
- ☐ Viability / Dating ≤ 14 weeks

Doppler Studies

- ☐ MCA Doppler (uobmca – 76821)
- ☐ UA Doppler (uobua – 76820)

Biophysical Profile (ubpp – 76819)

- ☐ BPP

Provider Signature : _____