Dartmouth-Hitchcock
MEDICAL CENTER

Department of Radiology
Please fax request to:
**Fax: (603) 653-6141**

# Referral Form
# Pelvic 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):** _____

_____

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**Study desired (please check):** *** Indicates additional information below is required.**

- * ❑ Transvaginal ( utv )
  (will be performed unless contraindicated)
- ❑ OI ( uoi ) _____ Baseline _____ Day
- * ❑ SHG ( ushg )
- ❑ Mock transfer ( met )
- ❑ IVF Harvest ( uivftv )
- * ❑ Transabdominal ( upel )
- ❑ Transabdominal guidance in OR ( upel / usp )
  (pre-approval required)
- ❑ Cyst aspiration ( ucyst )
- ❑ Embryo transfer ( uembry )

**Person providing the following information:** _____
(please print)

* LMP: _____

| | | | | | |
|---|---|---|---|---|---|
| * Peri-menopausal | ❑ Yes | ❑ No | **History of:** | | |
| * Post-menopausal | ❑ Yes | ❑ No | * Abnormal bleeding | ❑ Yes | ❑ No |
| * Pelvic pain | ❑ Yes | ❑ No | * Endometriosis | ❑ Yes | ❑ No |
| * On hormones | ❑ Yes | ❑ No | * Pelvic infections | ❑ Yes | ❑ No |
| * On Tamoxifen | ❑ Yes | ❑ No | * Ectopic pregnancy | ❑ Yes | ❑ No |
| * Previous children | ❑ Yes | ❑ No | * Tubes tied | ❑ Yes | ❑ No |
| * Previous pelvic surgeries | ❑ Yes | ❑ No | | | |

If yes, please describe: _____

_____

_____

**Provider Signature:** _____