Referral Form

Ultrasound Biopsy

Purpose:
To ensure all necessary lab requisitions are sent via fax to (603) 653-6141 so appropriate specimen containers can be available.

Policy:
For all procedure requests
All necessary lab slips/forms must accompany the procedure request form prior to approval and be completed filled out by the referring physician.

Once the request has been approved by the attending radiologist, a phone call will be made to the inpatient unit to request all the necessary forms. All necessary specimen requests must be completely filled out and will need to be faxed to Ultrasound at (603) 653-6141, prior to the patient arriving in Ultrasound.

This step will allow time to gather all the bottles and tubes necessary for the procedure. If an unusual request is needed, this will also help to secure the specimen container prior to the procedure.
Referral Form
Ultrasound Biopsy

Today’s Date: ______________________ Appointment Date:______________________ Appointment Time: ______________

Patient Name: ____________________________________________________________________________________________

MRN: _________________________________________________________ DOB: ____________________________________

Mailing address: ___________________________________________________________________________________________

Home phone: __________________________ Other: __________________________

Requesting Provider: _______________________________________________________________________________________

Address: __________________________ Pager #s: __________________________

Office phone: __________________________ Fax #: __________________________

Clinical History / Indication for this procedure: _______________________________________________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

Has the patient had a recent Ultrasound at DHMC? □ Yes □ No Date: ______________________________
If no, please bring outside images for review.

Specific area to be examined and/or biopsied: _______________________________________________________________

_________________________________________________________________________________________________________

Any contraindications (anticoagulant use, bleeding disorders, NSAIDS, aspirin, severe medical disease, COPD, allergies):

PT: _______________ PTT: _______________ INR: _______________ Date: ______________________________

Specific instructions re: sample management (culture, cytology, etc.)

**The requesting physician needs to send all necessary lab requisitions**

**Please instruct the patient to stop use of any aspirin, Plavix or NSAIDS 1 week prior to the biopsy procedure.**

Provider Signature: _______________________________________________________________________________________

**For Ultrasound Use Only**

Radiologist approval: _______________________________________________________________________________________

Exam Date: _______________ Time: _______________ Procedure Codes: __________________________

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