Dartmouth-Hitchcock
MEDICAL CENTER

Department of Radiology
Scheduling: (603) 650 - 7451
Fax: (603) 653 - 6141
Fax: (603) 650 - 0380

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):

_____

_____

ICD10 code: _____

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

☐ *Transvaginal (utv) IMG 3514

☐ Ovulation Induction – IMG 570

_____ Baseline _____ Day

☐ Endometrial Lining Check – IMG 570

☐ Antral Follicle Count – IMG 570

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 : _____