



**MOBILE  
ULTRASOUND  
SERVICES**

12659 South 125 East  
Ste B, Draper UT 84020  
Dispatch (801) 503-0500  
Fax (303) 801-523-6317

Date Ordered: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Scheduled: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE \_\_\_\_\_ STATION \_\_\_\_\_

Your Name \_\_\_\_\_

Your PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

FACILITY NAME/AGENCY \_\_\_\_\_

**BILLING INFORMATION** Bill Insurance  Bill Facility

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Other Insurance Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Responsible Party Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Type of Ultrasound Exam being Ordered:** \_\_\_\_\_

Name: \_\_\_\_\_ Bed / Room \_\_\_\_\_  
(Last) (First) Male / Female

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**For Residences & Care Homes**

Patient Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ordering Clinician: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*Clinician's Signature:** \_\_\_\_\_

Symptoms ABDOMINAL	Symptoms VASCULAR	Symptoms RENAL	Symptoms ARTERIAL	Echocardiogram For PMD Tech Use Only <input type="checkbox"/>																																																				
<input type="checkbox"/> Abdominal Mass <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abnormal Labs <input type="checkbox"/> Aneurysm - Aortic <input type="checkbox"/> Ascites <input type="checkbox"/> Cholecystitis <input type="checkbox"/> Cholelithiasis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Distention <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Liver Cyst <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pleural Effusion <input type="checkbox"/> RUQ Pain <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Aneurysm - Aortic <input type="checkbox"/> Aneurysm - Iliac <input type="checkbox"/> Aneurysm - Lower Ext <input type="checkbox"/> Aneurysm - Upper Ext <input type="checkbox"/> Atherosclerosis - Claudication <input type="checkbox"/> Atherosclerosis - Resting Pain <input type="checkbox"/> Cold Extremity <input type="checkbox"/> DVT <input type="checkbox"/> Edema <input type="checkbox"/> Hepatic Thrombosis <input type="checkbox"/> Limb Pain <input type="checkbox"/> Non Healing Wound / Ulcer <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Swelling Limb <input type="checkbox"/> Thrombosis Upper Ext <input type="checkbox"/> Weak Pulse	<input type="checkbox"/> Bladder Inflammation <input type="checkbox"/> Bladder Stones <input type="checkbox"/> Flank Pain <input type="checkbox"/> Renal Calculus <input type="checkbox"/> Renal Cyst <input type="checkbox"/> Renal Failure <input type="checkbox"/> Renal Infection <input type="checkbox"/> UTI <b>Small Parts</b> <input type="checkbox"/> Goiter <input type="checkbox"/> Hydrocele <input type="checkbox"/> Lump - Swelling <input type="checkbox"/> Neck Mass <input type="checkbox"/> Pain <input type="checkbox"/> Spermatocele <input type="checkbox"/> Testicular Atrophy <input type="checkbox"/> Thyroid - Abnormal Scan	<input type="checkbox"/> Abnormal gait <input type="checkbox"/> Amnesia <input type="checkbox"/> Aphasia <input type="checkbox"/> Broit <input type="checkbox"/> Carotid Stenosis <input type="checkbox"/> CHF <input type="checkbox"/> Chest Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Lack of Cord <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis -Transient <input type="checkbox"/> Subclavian Steal <input type="checkbox"/> Syncope <input type="checkbox"/> TIA <input type="checkbox"/> Visual Disturbance <input type="checkbox"/> Other	<table border="1"> <thead> <tr> <th>ID #</th> <th>Exams</th> </tr> </thead> <tbody> <tr><td>76700</td><td>Abdomen complete</td></tr> <tr><td>76705</td><td>Abdomen LTD</td></tr> <tr><td>93922</td><td>Ankle Brachial Index - ABI</td></tr> <tr><td>93978</td><td>Aorta Complete</td></tr> <tr><td>93975</td><td>Aortal (Abdominal) Full</td></tr> <tr><td>93976</td><td>Aortal (Abdominal) LTD</td></tr> <tr><td>93925</td><td>Arterial Lower Extr Bilat</td></tr> <tr><td>93926</td><td>Arterial Lower Extr Uni ( Lt / Rt).</td></tr> <tr><td>93930</td><td>Arterial Upper Extr Bil</td></tr> <tr><td>93931</td><td>Arterial Upper Extr Uni (Lt. / Rt.)</td></tr> <tr><td>93922</td><td>Ankle Brachial Index - ABI</td></tr> <tr><td>93880</td><td>Carotid Bilateral</td></tr> <tr><td>93882</td><td>Carotid Uni (Lt. / Rt.)</td></tr> <tr><td>76536</td><td>Head/Neck Thyroid)</td></tr> <tr><td>76857</td><td>Pelvic Limited Or F/U</td></tr> <tr><td>76856</td><td>Pelvic Trans AB</td></tr> <tr><td>76770</td><td>Retroperitoneal</td></tr> <tr><td>76870</td><td>Scrotum and Contents - Soft Tissue</td></tr> <tr><td></td><td>Soft Tissue</td></tr> <tr><td>76604</td><td>Ultrasound Chest</td></tr> <tr><td>93970</td><td>Venous Upper Extr Bilat.</td></tr> <tr><td>93970</td><td>Venous Lower Extr Bilat</td></tr> <tr><td>93971</td><td>Venous Upper Extr Uni (Lt. / Rt.).</td></tr> <tr><td>93971</td><td>Venous Lower Extr Uni (Lt./ Rt)</td></tr> <tr><td></td><td>Other : _____</td></tr> </tbody> </table>	ID #	Exams	76700	Abdomen complete	76705	Abdomen LTD	93922	Ankle Brachial Index - ABI	93978	Aorta Complete	93975	Aortal (Abdominal) Full	93976	Aortal (Abdominal) LTD	93925	Arterial Lower Extr Bilat	93926	Arterial Lower Extr Uni ( Lt / Rt).	93930	Arterial Upper Extr Bil	93931	Arterial Upper Extr Uni (Lt. / Rt.)	93922	Ankle Brachial Index - ABI	93880	Carotid Bilateral	93882	Carotid Uni (Lt. / Rt.)	76536	Head/Neck Thyroid)	76857	Pelvic Limited Or F/U	76856	Pelvic Trans AB	76770	Retroperitoneal	76870	Scrotum and Contents - Soft Tissue		Soft Tissue	76604	Ultrasound Chest	93970	Venous Upper Extr Bilat.	93970	Venous Lower Extr Bilat	93971	Venous Upper Extr Uni (Lt. / Rt.).	93971	Venous Lower Extr Uni (Lt./ Rt)		Other : _____
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**For PMD Technologist Use Only**

- Exam Not Completed
- Facility Cancelled
  - Patient Not Available
  - Patient Refused
  - Patient Uncooperative
  - System Failure

Notes: \_\_\_\_\_

**Postitive Exam Signature:**

Tech Name \_\_\_\_\_ Study Date / Time \_\_\_\_\_

Exam \_\_\_\_\_ # of Views \_\_\_\_\_ # of Retakes \_\_\_\_\_

Transport \_\_\_\_\_ Single (R0070) \_\_\_\_\_ Multi (R0075) \_\_\_\_\_ # of Patients \_\_\_\_\_