



**MOBILE
ULTRASOUND
SERVICES**

12659 S. 125 East, Ste B
Draper UT 84020
Dispatch (801) 503-0500
Fax (801) 783-4657

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 Small Parts <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: _____

Positive Exam Signature:

Tech Name _____ Study Date / Time _____

Exam _____ # of Views _____ # of Retakes _____

Transport _____ Single (R0070) _____ Multi (R0075) _____ # of Patients _____