VERMONT DIAGNOSTIC IMAGING

426 Industrial Ave, Suite 131, Door A4
Williston, VT 05459
Open Monday-Friday, 8a-4:30p
Phone: 802-988-7226 | Fax: 802-988-7329

☐ **URGENT**

ULTRASOUND ORDER FORM

PATIENT INFORMATION **DATE:** _____

Name: _____ DOB: _____ Phone: _____

Reason for Exam/ICD-10: _____

Ordering Provider: _____ Phone/Fax: _____

Allow for Radiologist discretion to change order (per ACR recommendations)? ☐ YES ☐ NO

HEAD & NECK

☐US HEAD/NECK SOFT TISSUE (lump/bump)
Area of interest: _____
☐US CHEST/BACK (soft tissue)
Area of interest: _____
☐US THYROID

BREAST

☐US BREAST LIMITED (abscess) ☐RIGHT ☐LEFT
☐US BREAST COMPLETE (screen) ☐RIGHT ☐LEFT

ABDOMEN/PELVIC ☐ w/ Doppler if indicated

☐US ABDOMEN COMPLETE
☐US ABDOMEN LIMITED
Area of interest: _____
☐US RENAL COMPLETE
☐US RENAL LIMITED
☐US PELVIC COMPLETE
☐US PELVIC LIMITED
☐US PELVIC & TRANSVAGINAL COMPLETE
☐US TRANSVAGINAL
☐US SCROTUM

OBSTETRICS (LIMITED TO <14 WEEKS)

☐US PELVIC AND TRANSVAGINAL OB <14WKS
☐US LIMITED OB

EXTREMITIES (NON-VASCULAR/SOFT TISSUE)

☐US UPPER EXTREMITY ☐RIGHT ☐LEFT
Area of interest: _____
☐US LOWER EXTREMITY ☐RIGHT ☐LEFT
Area of interest: _____

EXTREMITIES (MUSKULOSKELATAL)

☐US UPPER EXTREMITY ☐RIGHT ☐LEFT
Joint: _____
☐US LOWER EXTREMITY ☐RIGHT ☐LEFT
Joint: _____

EXTREMITIES (VASCULAR)

☐US UPPER EXTREMITY ☐RIGHT ☐LEFT
☐VENOUS (R/O DVT)
☐ARTERIAL
☐US LOWER EXTERMITY ☐RIGHT ☐LEFT
☐VENOUS (R/O DVT)
☐ARTERIAL

VASCULAR

☐US CAROTIDS BILATERAL
☐US ABDOMINAL AORTA SCREENING
☐US ABDOMINAL AORTA DIAGNOSTIC
☐US RENAL ARTERIES

We do **NOT currently perform the following studies: Infant/pediatric head/hips/pyloric stenosis; vascular mapping or insufficiencies; ankle brachial indices or transcranial doppler.*

PROVIDER SIGNATURE: _____ **DATE:** _____

Please fax signed order to 802-988-7329 and we will call your patient to schedule.
For **URGENT/same day add-ons** please call 802-988-7226 and we will be happy to accommodate.