SWEDISH | HEALTH FOR GOOD

SWEDISH MEDICAL IMAGING

SWEDISH FIRST HILL OBSTETRIC ULTRASOUND REQUISITION FORM

Swedish First Hill Ultrasound **Today's date:** _____

747 Broadway, Seattle, WA 98122 • 1229 Madison St., Suite 615, Seattle, WA 98104

Patient information: *(All fields are required)*

Patient legal name: _____ Date of birth: _____

Patient phone number:_____ ☐ Male ☐ Female ☐ Other: _____ Height: _____ Weight: _____

☐ Call patient to schedule ☐ Need interpreter (language): _____ Need assistive: ☐ Hearing ☐ Visual device

Pregnant? ☐ Yes ☐ No **Diabetic?** ☐ Yes ☐ No **Allergies?** ☐ Contrast ☐ Iodine ☐ Latex ☐ Other: _____

Insurance/Plan: _____ Member #/ID: _____ ☐ Uninsured ☐ Self-pay

Authorization #: _____ Valid date(s): _____ ☐ L & I, Claim #: _____

Ordering provider: *(All fields are required)*

Physician printed name: _____ NPI: _____ Phone: _____

Signature: (required) _____ Date/Time: _____

Clinic contact: _____ Clinic fax: _____

In event of critical finding, contact: _____ Phone: _____

Reason for exam: *(All fields are required)*

☐ ASAP ☐ Routine Symptoms/Diagnosis: _____

Reason for exam: _____

_____ ICD-10: _____ CPT code(s): _____

Reports are always faxed. ☐ Fax ***additional*** report to: Dr._____ Fax: _____

Prior films? ☐ No ☐ Yes, where? _____ If injured, date of injury: _____

Swedish Image Transfer Request Form: https://www.swedish.org/services/medical-imaging/image-transfer-request

Comments/Instructions: _____

Decision support Vendor (G code) _____ Adherence code (M modifier) _____ ID _____ Score _____

Exam ordered:

☐ Singleton ☐ Twins ☐ Triplets ☐ Other: _____

☐ 1st trimester ☐ With transvaginal

- ☐ Size and dates, viability
- ☐ Nuchal translucency ☐ With blood test:_____
- ☐ Other:_____

☐ 2nd/3rd trimester ☐ With transvaginal cervix check ☐ With UA Doppler ☐ With MCA Doppler

- ☐ Fetal anatomy (preferred at 20 weeks)
- ☐ Fetal anatomy for **high risk pregnancy** (preferred at 20 weeks) High risk indication: _____
- ☐ Limited evaluation
  - ☐ AFI
  - ☐ Evaluation of placenta (previa, abruption, etc.)
  - ☐ Other, specify: _____
- ☐ Follow-up evaluation
  - ☐ Interval growth
  - ☐ Fetal abnormality, specify: _____
- ☐ Complete (growth with repeat of anatomy after initial 20-week ultrasound)
- ☐ Biophysical profile ☐ With AFI
- ☐ Transvaginal cervix check
- ☐ Amniocentesis (ordering provider to perform procedure)
- ☐ Other, specify: _____

Please fax order to 206-215-3035 or call 206-386-3990.
Thank you for choosing Swedish!