Top Ultrasound

Ultrasound Order Form

SUBMIT ORDERS TO
referrals@topultrasound.com

Please complete and email this form to referrals@topultrasound.com. Top Ultrasound will contact the patient to coordinate scheduling. For questions: 512-981-6378 | topultrasound.com

Ordering Provider / Clinic

Clinic / Practice Name

Ordering Provider

NPI (optional)

Phone

Fax

Email

Contact

Patient Information

Patient Name

Date of Birth

Phone

Email

Address / City

Scheduling Preference

☐ Routine ☐ Soonest available ☐ Provider call

Ultrasound Exam Requested

☐ Abdomen Complete
☐ Abdomen Limited
☐ Kidney / Bladder
☐ Pelvic Ultrasound
☐ Thyroid / Neck
☐ Soft Tissue
☐ Carotid Ultrasound
☐ CIMT Screening
☐ Venous Doppler / DVT
☐ Arterial / Vascular
☐ Breast Ultrasound
☐ Other

Laterality / Location

☐ Right ☐ Left ☐ Bilateral

Area / Location Details

Reason for Exam

Diagnosis / ICD-10 Code(s)

Symptoms / Clinical History

Relevant Notes / Special Instructions

Report Delivery

Fax Results To

Secure Email / Contact

Attention To

Provider Authorization

Provider Signature

Date

Printed Name

This form is for non-emergency outpatient ultrasound requests. For severe pain, chest pain, shortness of breath, heavy bleeding, suspected emergency, or urgent symptoms, patients should seek immediate medical care.