ADVANCED SONOGRAMS
of Alaska, inc

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- ☐ Routine
- ☐ Fax Prelim _____
- ☐ Call _____
- ☐ Hold and call _____
- ☐ Return PT to office

Patient's Name _____ Date of Birth _____

Referring Provider _____ Today's Date _____

Appointment Date _____ Time _____

(Please arrive at our office 15 minutes prior to your appointment time).

Preferred Providers with Aetna, Blue Cross Blue Shield, Cigna, First Choice Health, Tricare, Medicaid & Medicare

Exam Type

☐ OBSTETRIC

Assigned EDD _____ ☐ U/S Confirmed and/or ☐ LMP Based _____

Type of exam:

- ☐ Dating
- ☐ Nuchal Translucency
- ☐ Anomaly Screening
- ☐ Fetal Growth (Specify Reason)
- ☐ Biophysical Profile (Specify Reason)
- ☐ Other (Specify Reason)

☐ FETAL ECHOCARDIOGRAM Reason _____

☐ PELVIC (Includes endovaginal exam unless otherwise specified). ☐ No endovaginal scan

☐ FOLLICULAR EXAM LMP _____ ☐ Antral Count _____

☐ ABDOMEN (liver, aorta, gallbladder, pancreas, kidneys, spleen)

☐ RENAL (kidneys, bladder)

☐ THYROID

☐ BREAST ☐ RT ☐ LT Please illustrate - - >

☐ TESTICULAR

☐ CAROTID

☐ AORTA

☐ VENOUS DOPPLER ☐ RT ☐ LT ☐ Lower extremity ☐ Upper Extremity

☐ OTHER EXAM

Details / Symptoms (please no R/Os): _____

_____

_____

GRANTED ACCREDITATION AIUM 2014–2017

EXAM PREP INSTRUCTIONS
AND MAP ON REVERSE