advanced
SONOGRAMS OF ALASKA

ADVANCED SONOGRAMS OF ALASKA
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☐ Routine
☐ Fax #_____
☐ Call report tc # _____
☐ Hold and call
☐ Return PT to office

Patient's Name:_____ Date of birth:_____

Referring Provider:_____ Today's Date:_____

Authorizing Signature:_____

Appointment Date:_____ Time:_____ Phone:_____

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

***MUST PROVIDE REASON FOR EXAM:** _____

_____

_____

OBSTETRIC - ASSIGNED EDD_____

BASED ON: ☐ LMP_____ ☐ U/S Confirmed

☐ DATING / VIABILITY
☐ 1ST TRIMESTER
☐ NUCHAL TRANSLUCENCY
☐ 2ND TRIMESTER
☐ ANOMALY SCREENING
☐ FETAL GROWTH ☐ W/Dopplers
☐ W/TV C-Sec. Scar Evaluation
☐ BIOPHYSICAL PROFILE ☐ W/Dopplers
☐ W/Growth
☐ W/TV C-Sec Scar Eval.
☐ FETAL ECHOCARDIOGRAM

GYN

☐ PELVIC (includes vaginal scan) ☐ No Vaginal Scan
☐ FOLLICLE STUDY LMP _____
☐ SONOHYSTEROGRAM ☐ W/Tubal Patency Study
☐ OTHER: _____

GENERAL

☐ ABDOMEN COMPLETE - RUQ
☐ ABDOMEN LIMITED
Specify_____
☐ RENAL COMPLETE (kidneys, bladder, retroperitoneum)
☐ AORTA COMPLETE
☐ AAA SCREENING
☐ THYROID - Head / Neck
☐ TESTICULAR
☐ EXTREMITY - Soft Tissue
Specify_____
☐ HERNIA EVALUATION ☐ Abd wall
☐ Groin ☐ Right ☐ Left
☐ OTHER: _____

VASCULAR

☐ VENOUS DOPPLER LEGS ☐ Right ☐ Left
☐ VENOUS DOPPLER ARMS ☐ Right ☐ Left
☐ CAROTID DOPPLER
☐ AORTO-ILIAC DOPPLER
☐ ARTERIAL DOPPLER LEGS ☐ Right ☐ Left
☐ ARTERIAL DOPPLER ARMS ☐ Right ☐ Left
☐ RENAL ARTERIAL DOPPLER
☐ PORTO-HEPATIC DOPPLER
☐ HEMODIALYSIS ACCESS DOPPLER

2021-2024 aium ACCREDITATION

Preferred Providers with Aetna, Blue Cross Blue Shield, First Choice Health, Tricare, Medicaid, Medicare and United Health Care.

EXAM PREP INSTRUCTIONS AND MAP ON REVERSE