OBSTETRIC ULTRASOUND RADIOLGY ORDER FORM

ULTRASOUND SCHEDULING PHONE: 206-598-6211
SCHEDULING FAX: 206-597-4004
RADIOLOGIST LINE (Providers Only): 206-598-0101

Last Name: ___________________________ FirstName: ___________________________ Date of Birth: ___________________________
Daytime phone: ___________________________ Evening phone: ___________________________ Gender: M F Weight: ___________________________
Insurance Carrier: ___________________________ Insurance ID#: ___________________________ Interpreter/Language: ___________________________

EXAM INFORMATION

HISTORY/REASON FOR EXAM:

QUESTIONS TO BE ANSWERED BY IMAGING:

ICD-10: ___________________________

(Please indicate if exam is considered “clinically urgent”)

OBSTETRIC ULTRASOUND

LMP: ___________________________ EDC: ___________________________ EDC based upon LMP/Ultrasound/Other: ___________________________
Number of Fetuses: ___________________________ 1st Trimester: ___________________________ With Transvaginal
□ Singleton □ Twins □ Triplets □ Other: ___________________________
□ 1st Trimester □ Size, dates, and viability □ Nuchal translucency □ Other, specify: ___________________________
□ 2nd Trimester □ Fetal anatomy for low-risk pregnancy (preferred at 20 weeks) □ Fetal anatomy for high-risk pregnancy (preferred at 20 weeks) □ UA doppler □ MCA doppler □ Limited evaluation □ AFI □ Evaluation of placenta (previa, abruption, etc.) □ Other, specify: ___________________________
□ Follow-up evaluation □ Interval growth and limited follow-up of previously completed anatomy □ Fetal abnormality, specify: ___________________________
□ Biophysical profile □ Transvaginal cervical length □ Other, specify: ___________________________

HIGH-RISK INDICATION

□ Known or suspected fetal anomaly □ Previous fetus or child with a congenital structural or genetic anomaly □ Fetal growth disorder □ Abnormal amniotic fluid (oligohydramnios or polyhydramnios) □ Maternal age ≥ 35 years at delivery □ Maternal body mass index ≥ 30kg/m2 □ Premedication diabetes or gestational diabetes diagnosed < 24 weeks □ Nuchal translucency measurement of ≥ 3.0mm □ Abnormal maternal genetic screening (serum analytes or cell free DNA) □ Soft aneuploidy marker noted on ultrasound □ Conceived via assisted reproductive technology □ Parental carrier of a genetic abnormality □ Multiple gestation □ Teratogen exposure □ Suspected placenta accreta spectrum or risk factors for placenta accreta (i.e., placental location overlying a prior hysterotomy site) □ Maternal drug dependence □ Maternal cell free DNA

Prior Related Imaging Type: ___________________________
Anatomy Scan Completed: Y N Facility: ___________________________ Date: ___________________________

Reporting 24/7 contact # for urgent abnormal results: ___________________________

Provider Fax: ___________________________

Provider Signature (required) ___________________________ Provider Name (please print) ___________________________
(Provider signature required. Do not use rubber stamp) (If first time referral)

Provider NPI #: ___________________________ Clinic Location: ___________________________

Please fill out form completely fax with chart notes
UW Medical Center - Montlake
1959 NE Pacific Street, 2nd Floor
Seattle, WA 98195

UW Medical Center - Roosevelt
4245 Roosevelt Way NE, 2nd Floor,
Seattle, WA 98105

UW Medical Center - Roosevelt
4245 Roosevelt Way NE, 2nd Floor,
Seattle, WA 98105

Northwest Outpatient Medical Center
10330 Meridian Ave N, Suite 130,
Seattle, WA 98133

UW Medicine Eastside Specialty Center
3100 Northup Way,
Bellevue, WA 98004

UW Maternal Fetal Medicine Clinic at Arlington
3823 172nd St NE
Arlington, WA 98223

FOR RADIOLOGY IMAGES & REPORTS:
UW RADIOLOGY RECORDS: Tel: 206-598-6206 Fax: 206-598-7690
NW RADIOLOGY RECORDS: Tel: 206-668-1748 Fax: 206-688-1398