

OBSTETRIC ULTRASOUND RADIOLOGY ORDER FORM

UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

Not a Maternal Fetal Medicine Consult Request

ULTRASOUND SCHEDULING PHONE: 206-598-6211

SCHEDULING FAX: 206-597-4004

RADIOLOGIST LINE (Providers Only): 206-598-0101

**Form must be completely filled
Fax with chart notes**

Last Name: _____ First Name: _____ Date of Birth: _____
Phone: _____ Address: _____ 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: Singleton Twins Triplets Other: _____

- 1st Trimester With Transvaginal
- 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 ≥ 30 kg/m²
- Pregestational diabetes or gestational diabetes diagnosed < 24 weeks
- Nuchal translucency measurement of ≥ 3.0 mm
- 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
- Alloimmunization

Order may be modified as clinically indicated: _____

Prior Related Imaging Type: _____ Facility: _____ Date: _____

Anatomy Scan Completed: Y N Facility: _____ Date: _____

Reporting **24/7 Contact Phone# for Urgent Abnormal Results:** _____
report auto faxed

Provider Fax: _____

Provider Signature (required)

(Provider signature required. Do not use rubber stamp)

Provider Name (please print)

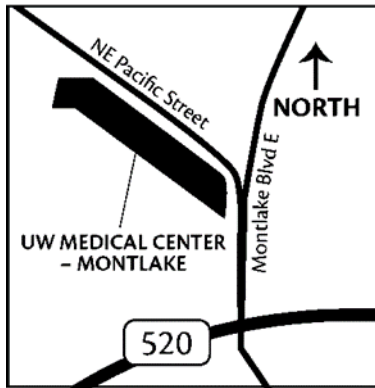
Phone

Date

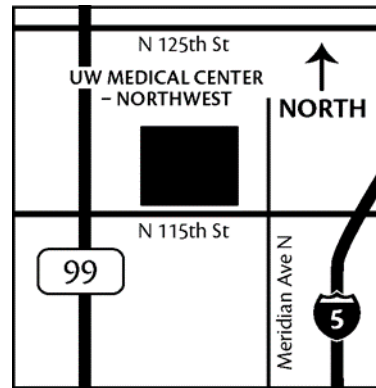
Time

Provider NPI #: _____ Clinic Location: _____

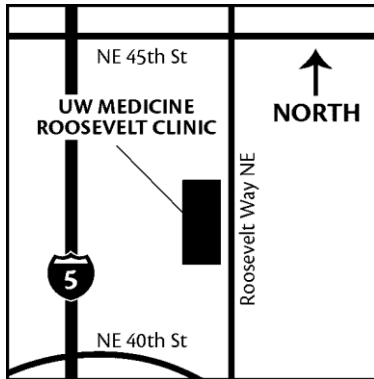
(If first time referral)



UW Medical Center - Montlake
1959 NE Pacific Street, 2nd Floor
Seattle, WA 98195



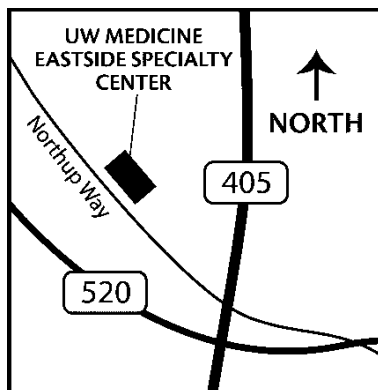
UW Medical Center - Northwest
1550 N 115th St, 2nd Floor,
Seattle, WA 98133



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