Dartmouth-Hitchcock
MEDICAL CENTER

Department of Radiology
Please fax request to:
Fax: (603) 653-6141

Referral Form
Ultrasound Biopsy

Procedure Request Information

Purpose:

To ensure all necessary lab requisitions are sent via fax to **(603) 653-6141** so appropriate specimen containers can be available.

Policy:

For all procedure requests

All necessary lab slips/ forms must accompany the procedure request form prior to approval and be completed filled out by the referring physician.

Once the request has been approved by the attending radiologist, a phone call will be made to the inpatient unit to request all the necessary forms. All necessary specimen requests must be completely filled out and will need to be faxed to **Ultrasound at (603) 653-6141**, prior to the patient arriving in Ultrasound.

This step will allow time to gather all the bottles and tubes necessary for the procedure. If an unusual request is needed, this will also help to secure the specimen container prior to the procedure.

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Referral Form
Ultrasound Biopsy

Today's Date: _____ Appointment Date:_____ Appointment Time: _____

Patient Name: _____

MRN: _____ DOB: _____

Mailing address: _____

Home phone: _____ Other: _____

Requesting Provider: _____

Address: _____ Pager #s: _____

Office phone: _____ Fax #: _____

Clinical History / Indication for this procedure: _____

_____

_____

Has the patient had a recent Ultrasound at DHMC? ❑ Yes ❑ No Date: _____
If no, please bring outside images for review.

Specific area to be examined and/or biopsied: _____

_____

_____

Any contraindications (anticoagulant use, bleeding disorders, NSAIDS, aspirin, severe medical disease, COPD, allergies):

PT: _____ PTT: _____ INR: _____ Date: _____

Specific instructions re: sample management (culture, cytology, etc.)
The requesting physician needs to send all necessary lab requisitions

****Please instruct the patient to stop use of any aspirin, Plavix or NSAIDS 1 week prior to the biopsy procedure.****

Provider Signature: _____

*****For Ultrasound Use Only*****

Radiologist approval: _____

Exam Date: _____ Time: _____ Procedure Codes: _____