Ultrasound Diagnostic Center
MB3 • 1500 W. 22nd St. • Suite 401
Sioux Falls, SD 57105
Phone: 605-328-4600 • Fax: 605-328-4601

Provider Service Order

Date: ______________________________

Priority: ☐ **High** (will be scheduled within 72 hrs)
☐ **First** Available/Patient Convenience

Patient Name: ______________________________

*Patient Address: ______________________________

DOB: ______ / ______ / ______ (mm/dd/yyyy)

Patient Contact #: (_________) ______________________

LMP:__________ EDD __________ by ☐ LMP or ☐ Early US

G_______ T_______ P_______ A______ L_______

*Insurance Company: ______________________________

*Group# and ID#: ______________________________

Provider Name: ______________________________

Referring Clinic/Site: ______________________________

Clinic Phone #:(_________) ______________________

Clinic Fax #: (_________) ______________________

Or FAX Patient's current Demographic sheet that includes this information.

SERVICE REQUESTED: please check all that apply

******Please fax entire prenatal record including any ultrasound reports, serum screens, blood type******

CONSULTATION - Reason for Consultation (Indication/Diagnosis): ______________________

Specific reason for request (Issue/concern): ______________________

☐ **Maternal-Fetal Medicine Consultation**

Proposed Management: ☐ One-time consultation ☐ Co-management ☐ Transfer of complete OB Care

☐ **Genetic Counseling Consultation**

OBSTETRICS - Reason for Ultrasound (Indication/Diagnosis): ______________________

☐ **Detailed Ultrasound** (at least 18 wk gestation) - fetal and maternal evaluation including biometry & a detailed anatomy evaluation. Includes Maternal-Fetal Medicine Consultation

☐ **Complete Ultrasound** (OB>14 wk gestation) - fetal and maternal evaluation including biometry & anatomy evaluation

☐ **Follow-up Ultrasound** (growth and anatomy)

☐ **Fetal Echocardiogram** (at least 22 wk gestation) - (Detailed Ultrasound is recommended in conjunction with this exam) Includes Maternal-Fetal Medicine Consultation

☐ **First Trimester Screen** (Ultrasound nuchal translucency and serum markers, between 11 to 13 weeks 6 days gestation/includes genetic counseling)

☐ **OB <14 Weeks** (Transvaginal or transabdominal)

☐ **Cervical Length Assessment** (Performed transvaginally)

PROCEDURE - Reason for Procedure (Indication/Diagnosis): ______________________

☐ **Chorionic Villus Sampling** (done between 10-14 weeks)

☐ **Genetic Amniocentesis** (generally ≥15 weeks gestation) ☐ **Lung Maturity Amniocentesis**

FETAL SURVEILLANCE - Reason for Fetal Surveillance (Indication/Diagnosis): ______________________

☐ **Biophysical Profile w/o NST (BPP)** Begin at __________ ☐ one time only ☐ weekly ☐ twice weekly ☐ per MFM
Growth and anatomy assessment NOT included with this test.

☐ **Biophysical Profile with NST (BPP/NST)** Begin at __________ ☐ one time only ☐ weekly ☐ twice weekly ☐ per MFM
Growth and anatomy assessment NOT included with this test.

☐ **Non-Stress Test (NST)** Begin at __________ ☐ one time only ☐ weekly ☐ twice weekly ☐ per MFM
If NST non-reactive, will proceed to BPP.

☐ **Umbilical Artery Doppler** Begin at __________ ☐ one time only ☐ weekly ☐ twice weekly ☐ per MFM
Growth and anatomy assessment NOT included with this test.

GYN - (Performed transvaginally unless otherwise specified) - Reason for Ultrasound: (Indication/Diagnosis) ______________________

☐ **Gynecological Ultrasound** ☐ **Saline Infusion Sonogram** ☐ **3D Gynecological Ultrasound**

Physician/CNM/NP/PA Signature:______________________________

Reminder: A signed order request is required prior to any appointment.

Appointment:
DATE: ________________
TIME: ________________
Date/Initial: ________________

1-43-007 12/09