PATIENT INFORMATION

Name:_____ DOB: ____/_____/____

INDICATION / REQUEST DETAILS (*Required)

Reason for Exam*: _____

_____

_____

_____

Dating (Please check dating criteria below):

☐ EDD (estimated delivery date) not established

☐ Established EDD: _____/_____/_____

☐ Last Menstrual Period (LMP): _____/_____/_____

Study Desired (Please Check)*:

☐ Ob Anatomy scan	☐ EFW / Growth	☐ Growth Multiple Gestation
☐ Ob Limited	☐ UA Doppler	☐ Other _____
☐ Biophysical Profile	☐ MCA Doppler	
☐ Ob Transvaginal	☐ Ob Nuchal Translucency	
☐ Ob Cervical Length	☐ Re-evaluation / Abnormality Follow-up	

Multiple Gestation: ☐ Twins ☐ Triplets

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____

Ordering Provider Name (Print): _____

Ordering Provider Signature*: _____

Date: _____/_____/_____

4512 S. McColl Rd. Edinburg, Tx 78539 PHONE NUMBER: 956-515-2060