# PRENATAL DIAGNOSTIC ULTRASOUND ORDER FORM

## Image Of Love Ultrasoun, LLC

SELF-PAY ONLY

DIAGNOSTIC ULTRASOUND REQUESTED

### ORDERING PROVIDER INFORMATION

FACILITY NAME: _____

PHONE: _____

ADDRESS: _____

EMAIL: _____

PROVIDER NAME: _____

NPI NUMBER: _____

DATE: ____ / ____ / _____

### PATIENT INFORMATION

PATIENT FULL NAME: _____

DATE OF BIRTH: ____ / ____ / _____

PHONE NUMBER: _____

### PREGNANCY INFORMATION

LAST MENSTRUAL PERIOD (LMP): ____ / ____ / _____

ESTIMATED DUE DATE (EDD): ____ / ____ / _____

GRAVIDA / PARA: _____ / _____

□ SINGLETON □ MULTIPLE GESTATION

(CHECK ALL THAT APPLY)

□ DATING
□ FIRST TRIMESTER DIAGNOSTIC ULTRASOUND
□ ANATOMY SCAN (18–22 WEEKS)
□ GROWTH / FOLLOW-UP ULTRASOUND
□ BIOPHYSICAL PROFILE (BPP)
□ PLACENTA EVALUATION
□ CERVICAL LENGTH EVALUATION
□ AMNIOTIC FLUID INDEX (AFI)
□ MULTIPLE GESTATION EVALUATION
□ OTHER DIAGNOSTIC EXAM: _____

### CLINICAL INDICATION / MEDICAL NECESSITY

□ ROUTINE PRENATAL EVALUATION
□ SIZE / DATE DISCREPANCY
□ VAGINAL BLEEDING
□ DECREASED FETAL MOVEMENT
□POST DATES
□ FOLLOW-UP FROM PRIOR DIAGNOSTIC SCAN
□ OTHER: _____
ADDITIONAL NOTES / SPECIAL INSTRUCTIONS

☑ SELF-PAY PATIENT

INSURANCE BILLING IS NOT ACCEPTED FOR THIS DIAGNOSTIC ULTRASOUND SERVICE.
PAYMENT IS DUE AT THE TIME OF SERVICE.