WAVE ULTRASOUND, LLC

8987 W FLAMINGO RD #S105 OFFICE 103 Las Vegas, NV 89147
Tel (702) 861-8885 * Fax (702) 825-2715
Email : waveultrasoundllc@gmail.com

Echo/Ultrasound/Doppler Requisition

Patient's Name: ____ **Test Date:** _____________

DOB: ____/____/_____ **Sex** ______ **Insurance Type** [ ] **PPO** [ ] **Medicare** [ ] **Other**_______________

( ) ABDOMEN 76700
( ) Alcoholic Cirrhosis of Liver
( ) Chronic Hepatitis, Unsp.
( ) Cirrhosis of Liver NOS
( ) Chronic Liver Disease Unsp
( ) Calculus of Gallbladder
( ) Chronic Cholecystitis
( ) Disease of Pancreas Unsp.
( ) Abdominal Pain
( ) Hepatomegaly
( ) Splenomegaly
( ) Abdominal Swelling
( ) Ascites
( ) Other ____________________

( ) PELVIC 76856
( ) Fibroid Uterus
( ) Pelvic Inflamm. Disease
( ) Ovarian Cyst
( ) Enlarged Uterus
( ) Vaginal Bleeding
( ) Dysmenorrhea
( ) Pelvic Pain
( ) Pelvic Mass
( ) Other ____________________

( ) RETROPERITONEAL
(Renal, Aorta) 76770
( ) Renal Failure
( ) Renal Infection
( ) Hydronephrosis
( ) Renal Calculus
( ) Renal Cyst
( ) UTI
( ) Hematuria
( ) Renal Colic
( ) Other ___________________

( ) THYROID 76536
( ) Thyroid Mass
( ) Goiter, Unspecified
( ) Thyroid Nodule
( ) Thyroid Cyst
( ) Neck Mass
( ) Abnormal Thyroid Test
( ) Other ___________________

ARTERIAL DUPLEX
( ) 93930 Bilateral Upper
( ) 93931 Unilateral Upper
( ) 93925 Bilateral Lower
( ) 93926 Unilateral Lower

( ) DM II Control W/PCD
( ) DM I Control W/PCD
( ) DM II Uncontrolled W/PCD
( ) DM I Uncontrolled W/PCD
( ) Atheroscler. of Ext. Unspec.
( ) Atherosclerosis W/ Claud
( ) Atheroscleros. W/Rest Pain
( ) Aneurysm Upp. Extremity
( ) Aneurysm Low. Extremity
( ) PVD, Unspecified
( ) Art. Embolism and Thromb
( ) Stricture of Artery
( ) Arteritis unspecified
( ) Circulatory Sys. Disord. Uns
( ) End Stage Renal Disease
( ) Pain in Limb
( ) Swelling Limb
( ) Weak Pulse
( ) Other ____________________

VENOUS DUPPLER STUDY
( ) 93970 Bilateral Lower
( ) 93971 Unilateral Lower

( ) Phlebitis/Thrombophlebitis
( ) Varicose Vein W/Ulceration
( ) Varicose Vein W/ Inflammation
( ) Varicose Vein w/o Ulceration
( ) Post Phlebitis Syndrome
( ) Pain in Limb
( ) Swelling Limb
( ) Local. Superficial Swelling, Mass, Lump.
( ) Edema
( ) Ulcer Calf
( ) Ulcer Ankle
( ) Other ____________________

( ) CAROTID DUPLEX 93880

( ) Carotid Stenosis
( ) TIA
( ) Cerebral Atherosclerosis
( ) Amnesia
( ) Syncope and Collapse
( ) Dizziness and Giddiness
( ) Abnormal Gait
( ) Lack of Coordination
( ) Paralysis Transient
( ) Headaches
( ) Aphasia
( ) Other Speech Disturbance
( ) Carotid Bruit
( ) Syncope
( ) Other ______________________

( ) ECHOCARDIOGRAM 93306

( ) Essential hypertension Unspecified
( ) Hypert. Heart Disease w/o HF
( ) Hypert. Heart Disease with HF
( ) Angina pectoris Unspecified
( ) Chronic Coronary Insuficiency
( ) Coronary Atherosclerosis
( ) ASHD
( ) Aneurism Card
( ) Ischemic Heart Disease
( ) Pericarditis
( ) Mitral Valve Disorder
( ) Aortic Valve Disorder
( ) Cardiomyopathy
( ) Endocarditis
( ) Cardiac Arrhythmia
( ) CHF
( ) Cardiomegaly
( ) Mitral Thrombosis
( ) Hyperkinetic Heart Disease
( ) Heart Disease Unspecified
( ) Heart Palpitation
( ) Chest Pain Unspecified
( ) Chest Tightness/Pressure
( ) Other ________________________

Referring Physician Statement

I certify that the above prescribed service(s) is/are medically indicated and in my opinion is/are_reasonable and necessary with reference to all professional medical standards and treatment of patient's condition.

_________________________ _________________________ _____________________

Printed Name Signature Date