



Physician/Provider Referral Form

1216 16th St. W. · Alpine Village Suite 21 · Billings, MT 59102 · (406) 969-4340 · www.PicturePerfectUltrasound.com

DATE:			
PATIENT INFORMATION			
PATIENT NAME:		DOB:	PHONE #:
INSURANCE:		INSURANCE ID #:	
PHYSICIAN/PROVIDER INFORMATION			
PHYSICIAN/PROVIDER NAME:			NPI #:
FACILITY NAME:			
ADDRESS:		CITY:	ST:
PHONE #:		CELL/PAGER #:	FAX #:
REFERRAL INFORMATION			
ULTRASOUND EXAM REQUESTED:			
<input type="checkbox"/> AORTA	<input type="checkbox"/> OB <13 WEEKS	<input type="checkbox"/> NEONATAL HEAD	
<input type="checkbox"/> ABDOMEN (UPPER/COMPLETE)	<input type="checkbox"/> OB >14 WEEKS	<input type="checkbox"/> TESTICULAR	
<input type="checkbox"/> ABDOMEN LIMITED	<input type="checkbox"/> BIOPHYSICAL PROFILE	<input type="checkbox"/> THYROID/PARATHYROID	
<input type="checkbox"/> ABDOMINAL DOPPLER	<input type="checkbox"/> OB Follow Up	<input type="checkbox"/> SOFT TISSUE	
<input type="checkbox"/> BLADDER ONLY	<input type="checkbox"/> OB LTD (specify what is to be scanned EX: Heart Only or Brain Only)	<input type="checkbox"/> CAROTID DUPLEX	
<input type="checkbox"/> RENAL (Kidneys Only)		<input type="checkbox"/> Groin <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILAT	
<input type="checkbox"/> RENAL & BLADDER		<input type="checkbox"/> HERNIA (Site: _____)	
<input type="checkbox"/> TRANSPLANT KIDNEY	<input type="checkbox"/> PELVIC COMPLETE (TA/TV)	<input type="checkbox"/> FERTILITY/FOLLICULAR	
<input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/> PELVIC TRANSVAGINAL		
<input type="checkbox"/> RENAL ARTERY DOPPLER/ DUPLEX	<input type="checkbox"/> PELVIC TRANSABDOMINAL		
LOWER EXTREMITY ARTERIAL: <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILAT		<input type="checkbox"/> ECHOCARDIOGRAM (Cardiac Ultrasound)	
LOWER EXTREMITY VENOUS DOPPLER: <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILAT			
LOWER EXTREMITY VENOUS VALVE COMP: <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILAT			
UPPER EXTREMITY ARTERIAL: <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILAT			
UPPER EXTREMITY VENOUS DOPPLER: <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> BILAT			
REASON FOR REFERRAL/PATIENT CLINICAL HX:			
ICD-10 CODE:		CPT CODE:	
ADDITIONAL PHYSICIAN/PROVIDER COMMENTS:			

Picture Perfect Ultrasound is digital with EMR and PACS system in place for Ultrasound Imaging, data storage and viewing. Our interpretive physicians are Licensed and Credentialed Radiologists & Cardiologists, experienced in the specialty of Ultrasound. The results are sent to the referring physician/provider the same day the Ultrasound is performed.

Physician/Provider Signature

Date

Please fax completed form to *Picture Perfect ultrasound* at: 406-969-4341

Picture Perfect Ultrasound is an approved in-network provider, accepting Insurance, Medicaid, Medicare, IHS, TriCare, TriWest and Self Pay Patients. We are able to accept in-state and out-of-state patients.