



WAVE MOBILE IMAGING

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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(kidneys) 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 _____ () Small Parts 76536 () Other _____	ARTERIAL DUPLEX () 93930 Bilateral Upper () 93931 Unilateral Upper () 93925 Bilateral Lower () 93926 Unilateral Lower () 93923 ABI Complete – 3 LEVEL () 93922 ABI Limited – 1 LEVEL () 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 () Atherosclerosis. 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 _____
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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