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Radiology Department ULTRASOUND Exam
 Phone: 617-573-3555 Fax: 617-573-3846

Patient Information

Date:

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|---------------------------|---|-----------------|------|
| Last Name: | First Name: | Middle Initial: | MRN# |
| Date of Birth: | Home Phone: | Work Phone: | |
| Street Address: | | | |
| City: | State: | Zip: | |
| INSURANCE CARRIER: | REFERRAL / AUTHORIZATION and/or TRANSACTION #: | | |

Ultrasound Procedures:

CPT:

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|---|---|
| <input type="checkbox"/> Head and Neck (soft tissues of head and neck: (thyroid, parathyroid, parotid)) | 76536 |
| <input type="checkbox"/> Guidance for Vascular Access (evaluation of access sites, documentation of vessel patency, and visualization of vascular needle entry) | 76937 |
| <input type="checkbox"/> Guidance for Needle Placement (biopsy, aspiration, injection, localization device) | 76942 |
| <input type="checkbox"/> Biopsy: circle one | 10022 fine needle, 20206 muscle, 20205 deep 38505 lymph node, 60100 thyroid |
| <input type="checkbox"/> Other | |
| <input type="checkbox"/> Other | |
| <input type="checkbox"/> Other | |

Additional Patient History (be specific):

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| Date of Exam: | Time of Exam: | Initials: |
| Physician Ordering Exam (print name): | Physician Signature (required): | |
| Phone Extension: | | |