



GYN Ultrasound Referral

APPOINTMENTS: 808-535-7000 | PHONE: 808-983-8559 | FAX: 808-983-8989
Once an appointment is made, please fax complete form.

Appointment Date: _____ Appointment Time: _____

Patient Name: _____

Date of Birth: _____ G: _____ P: _____

Requesting/Referring Physician: _____

Office Phone Number: _____

PROCEDURE REQUESTED (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Complete GYN Ultrasound 76856, 76830
(transabdominal and transvaginal ultrasound) | <input type="checkbox"/> 3D Sonohysterography (saline infusion sonography/SIS)
of uterus 76831, 58340, 76376 (indicated for
of possible congenital uterine anomalies) |
| <input type="checkbox"/> Transabdominal GYN Ultrasound only 76856
(transvaginal ultrasound will not be done) | <input type="checkbox"/> 3D ultrasound of uterus without SIS 76376
(indicated for IUD localization) |
| <input type="checkbox"/> Doppler (pelvic organ/ovary) 93976 | <input type="checkbox"/> If the physician sinologist recommends additional
Ultrasound services, do you want us to order and
schedule the service?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> 2D Sonohysterography (saline infusion sonography/SIS)
of uterus 76831, 58340, 76856, 76830 (indicated for evaluation
of possible polyps, submucous myomata, etc.) | |

****SIS procedures will not be performed if there is a possibility of pregnancy, if there is a current pelvic infection (PID), or if an IUD is present in the uterus. In a woman with regular menstrual cycles, SIS should not be scheduled later than the 10th day of the menstrual cycle. Please see patient information sheet "How to prepare for sonohysterography" provided by KMCWC.**

REFERRED FOR THE FOLLOWING GYN INDICATIONS (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Adenomyosis | <input type="checkbox"/> Hydrosalpinx | <input type="checkbox"/> Pelvic mass |
| <input type="checkbox"/> Amenorrhea, primary | <input type="checkbox"/> Infertility, female | <input type="checkbox"/> Personal history breast cancer |
| <input type="checkbox"/> Amenorrhea, secondary | <input type="checkbox"/> Intermenstrual bleeding
(metrorrhagia) | <input type="checkbox"/> Personal history of ovarian cancer |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Irregular menstrual period | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Dyspareunia | <input type="checkbox"/> IUD complication | <input type="checkbox"/> Postmenopausal bleeding |
| <input type="checkbox"/> Endometrial hyperplasia | <input type="checkbox"/> IUD misplaced | <input type="checkbox"/> Prophylactic SERM (Tamoxifen) |
| <input type="checkbox"/> Endometrial polyp | <input type="checkbox"/> Left lower quadrant pain | <input type="checkbox"/> Retained POCs |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Menometrorrhagia | <input type="checkbox"/> Right lower quadrant pain |
| <input type="checkbox"/> Enlarged uterus | <input type="checkbox"/> Oligomenorrhea | <input type="checkbox"/> Uterine anomaly |
| <input type="checkbox"/> Family history breast cancer | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Family history ovarian cancer | <input type="checkbox"/> Pelvic Inflammatory disease (PID) | |
| <input type="checkbox"/> Fever | | |

COMMENTS: _____

PHYSICIAN SIGNATURE: _____