FLORIDA HEALTH CARE PLANS

ULTRASOUND REFERRAL FORM

Date Ordered:_____

A. NAME: _____ DOB: _____ FHCP #: _____

REFERRING PHYSICIAN: _____ PROV. #: _____

PCP: _____ PROV. #: _____

B. **ULTRASOUND EXAM REQUESTED**

Description	✓	CPT Code	No. of Films
Abdomen Complete		76700	
Abdomen Limited		76705	
Aorta		76770	
Gallbladder		76705	
Breast		76645	
Renal		76775	
Pelvic		76856	
Transvaginal		76830	
Testicular		76870	
Thyroid		76536	
Bakers Cyst		76880	
Carotid		93880	
Lower Extremity - Venous		93965	
Other			

C. Diagnostic Code:_____

D. **WRITTEN DIAGNOSIS AND "REASON FOR REQUEST"**
(ALSO IF FOLLOW-UP FROM OUTSIDE DIAGNOSTIC TEST, PLEASE ATTACH REPORT)

_____

_____

E. APPOINTMENT DATE: _____ TIME: _____

★ ★ ★ ***C & D MUST BE COMPLETED FOR APPOINTMENT TO BE SCHEDULED*** ★ ★ ★

TECH. NO.:_____

WHITE COPY - ULTRASOUND DEPT.; YELLOW COPY - REFERRING PROVIDER; PINK COPY - MEMBER

01-829/9-03P
FHCP - 140 - 9/03