OBSTETRIC ULTRASOUND RADIOLOGY ORDER FORM

Please fill out form completely fax with chart notes

UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

ULTRASOUND SCHEDULING PHONE: **206-598-6211**
SCHEDULING FAX: **206-597-4004**
RADIOLOGIST LINE (*Providers Only*): **206-598-0101**

☐ ARLINGTON MFM OB US ONLY
Phone: 206-598-7979
Fax: 360-659-5393

Last Name:_____ First Name:_____ Date of Birth:_____
Daytime phone:_____ Evening phone:_____ Gender: M F Weight:_____
Insurance Carrier:_____ Insurance ID#:_____ Interpreter/Language:_____

EXAM INFORMATION

HISTORY/REASON FOR EXAM:

QUESTIONS TO BE ANSWERED BY IMAGING:

ICD-10:

(*Please indicate if exam is considered "clinically urgent"*)

OBSTETRIC ULTRASOUND

LMP: | EDC: | EDC based upon LMP/Ultrasound/Other:

Number of Fetuses: ☐ Singleton ☐ Twins ☐ Triplets ☐ Other: _____

☐ 1st Trimester ☐ With Transvaginal
- ☐ Size, dates, and viability
- ☐ Nuchal translucency
- ☐ Other, specify:_____

☐ 2nd Trimester
- ☐ Fetal anatomy for **low-risk pregnancy** (preferred at 20 weeks)
- ☐ Fetal anatomy for **high-risk pregnancy** (preferred at 20 weeks)
- ☐ UA doppler
- ☐ MCA doppler
- ☐ Limited evaluation
  - ☐ AFI
  - ☐ Evaluation of placenta (previa, abruption, etc.)
  - ☐ Other, specify:_____
- ☐ Follow-up evaluation
  - ☐ Interval growth and limited follow-up of previously completed anatomy
  - ☐ Fetal abnormality, specify: _____
- ☐ Biophysical profile
- ☐ Transvaginal cervical length
- ☐ Other, specify:

HIGH-RISK INDICATION

- ☐ Known or suspected fetal anomaly
- ☐ Previous fetus or child with a congenital structural or genetic anomaly
- ☐ Fetal growth disorder
- ☐ Abnormal amniotic fluid (oligohydramnios or polyhydramnios)
- ☐ Maternal age ≥ 35 years at delivery
- ☐ Maternal body mass index ≥ 30kg/m2
- ☐ Pregestational diabetes or gestational diabetes diagnosed < 24 weeks
- ☐ Nuchal translucency measurement of ≥ 3.0mm
- ☐ Abnormal maternal genetic screening (serum analytes or cell free DNA)
- ☐ Soft aneuploidy marker noted on ultrasound
- ☐ Conceived via assisted reproductive technology
- ☐ Parental carrier of a genetic abnormality
- ☐ Multiple gestation
- ☐ Teratogen exposure
- ☐ Suspected placenta accreta spectrum or risk factors for placenta accreta (i.e., placental location overlying a prior hysterotomy site)
- ☐ Maternal drug dependence
- ☐ Alloimmunization

Prior Related Imaging Type:_____ Facility:_____ Date:_____
Anatomy Scan Completed: Y N Facility:_____ Date:_____

Reporting
report auto faxed

24/7 contact # for urgent abnormal results: _____
Provider Fax: _____

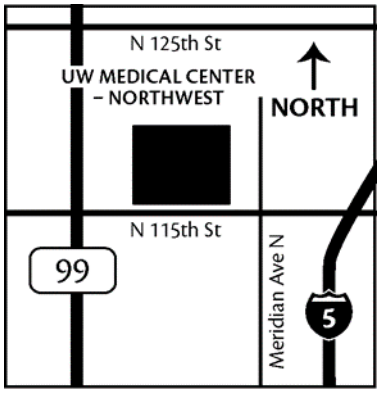
Provider Signature (required) | **Provider Name (please print)** | **Phone** | **Date** | **Time**

(Provider signature required. Do not use rubber stamp)

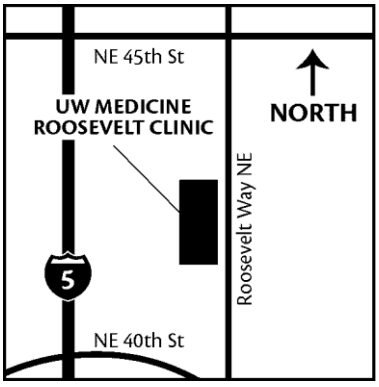
Provider NPI #: _____ **Clinic Location:**_____
(*If first time referral*)

https://rad.washington.edu/about-us/locations/

UW Medical Center - Montlake
1959 NE Pacific Street, 2nd Floor
Seattle, WA 98195

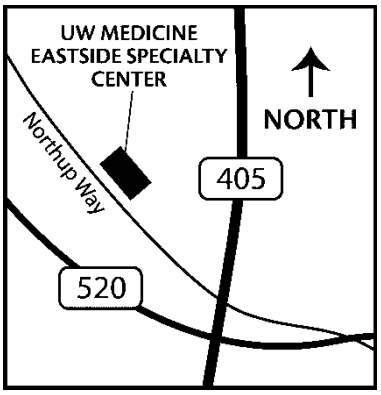


UW Medical Center - Northwest
1550 N 115th St, 2nd Floor,
Seattle, WA 98133



UW Medical Center – Roosevelt
4245 Roosevelt Way NE, 2nd Floor,
Seattle, WA 98105

Northwest Outpatient Medical Center
10330 Meridian Ave N, Suite 130,
Seattle, WA 98133



UW Medicine Eastside Specialty Center
3100 Northup Way,
Bellevue, WA 98004

UW Maternal Fetal Medicine Clinic at Arlington
3823 172nd St NE
Arlington, WA 98223

FOR RADIOLOGY IMAGES & REPORTS:
UW RADIOLOGY RECORDS: Tel: 206-598-6206 Fax: 206-598-7690
NW RADIOLOGY RECORDS: Tel: 206-668-1748 Fax: 206-688-1398