Medical Sonography Services, Inc

Radiologic and Imaging Services at Dallas Fort Worth

Established since 2008

Phone 214-483-5147 Fax 214-432-0627

For an Appointment Tel. 214-483-5147

CITA en ESPAÑOL Tel. 214-483-5147

Referral Form

Patient Information

Patient Name:______________________________________

Date of Birth:______________________________________

Phone:______________________________________

Appointment date:______________________________________

Study:______________________________________

Diagnosis:______________________________________

Referring Facility Information

Name: ______________________________________

Phone: ______________________________________

Fax: ______________________________________

Contact:______________________________________

Referring PhysicianName:______________________________________

X-RAY

- ☐ Chest
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine AP & Lat
- ☐ Abdomen
- ☐ Elbow Right / Left
- ☐ Hand Right / Left
- ☐ Pelvis Right / Left
- ☐ Femur Right / Left
- ☐ Knee Right / Left
- ☐ Ankle Right / Left
- ☐ Foot Right / Left
- ☐ Other________________________

☐ Transthoracic Echocardiogram

Diagnosis

- ☐ Hypertension esencial
- ☐ Chest Pain
- ☐ Congestive heart failure
- ☐ Other________________________

MRI

With Contrast____

Without Contrast____

- ☐ Abdomen
- ☐ Pelvis
- ☐ Chest / Thorax
- ☐ Head/Brain
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Other:____________________

Sonograms / Ultrasounds

- ☐ Complete Abdomen
- ☐ Liver
- ☐ Gallbladder
- ☐ Renal
- ☐ Urinary Bladder

Diagnosis

- ☐ Abdominal pain
- ☐ Dyslipidemia
- ☐ Fatty Liver

☐ **Testicular Sonogram**

Diagnosis

- ☐ Testicular Pain
- ☐ Other________________________

☐ **Thyroid**

Diagnosis

- ☐ Enlargement of the gland

Sonograms / Ultrasounds

- ☐ **Gynecologic**
- ☐ Transabdominal
- ☐ Transvaginal

Diagnosis

- ☐ Pelvic pain
- ☐ Other________________________

☐ **Breast Sonogram Right / Left**

Diagnosis

- ☐ Pain in breast
- ☐ Other________________________

☐ **Obstetric Sonogram**

- ☐ Transabdominal
- ☐ Transvaginal

Diagnosis

- ☐ Pregnancy documentation

Breast Mammogram 2D / 3D

- ☐ Screening Mammogram Right / Left
- ☐ Diagnostic Mammogram Right / Left

Patient has Breast Implants__Yes/ No__

☐ Venous Doppler Lower Extremeties

Right / Left

Diagnosis

- ☐ Leg pain
- ☐ Other______________________________

CT Scan

With Contrast____

Without Contrast____

- ☐ Abdomen & Pelvis
- ☐ Pelvis
- ☐ Chest
- ☐ Head/Brain
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Other:

Doctor's Signature:______________________________________ **Date:**__________________

In making this referral, referring physician certifies that the prescribed procedures is of medical necessity