



200 East Sheridan Road * Melbourne, FL 32901 * 321-725-4500 Ext. 531
7125 Murrell Road * Melbourne, FL 32940

REQUEST FOR ULTRASOUND EXAM

NAME: _____ D.O.B. _____ **DIAGNOSIS CODE** _____

Appt Date: _____ Time: _____ REFERENCING PHYSICIAN _____

CPT CODE

Complete Abdomen 76700 Complete Abdomen (liver, gb, pancreas,aorta)

*****NOTHING BY MOUTH AFTER MIDNIGHT*****

Abdominal Limited 76705 Limited – follow up from prior exam only

*****NOTHING BY MOUTH AFTER MIDNIGHT*****

Renal 76775 Bilateral Kidneys

****NO PREP****

Aorta 76775 Aorta only

****NO PREP****

Scrotal 76870 Scrotal contents

****NO PREP****

Pelvic – Non Obstetric 76856 Uterus, Ovaries

*****FULL BLADDER EXAMS *****

DRINK 32 ounces of **WATER** 1 hour prior to appointment time and **HOLD your bladder**

Bladder (limited pelvic) Pre & Post Void Bladder

*****FULL BLADDER EXAMS *****

DRINK 32 ounces of **WATER** 1 hour prior to appointment time and **HOLD your bladder**

Thyroid 76536 Thyroid

****NO PREP****

U/S Extremity 76880 For Popliteal Cyst or lump

Miscellaneous _____

PLEASE ARRIVE 10 MINUTES BEFORE EXAM TIME TO COMPLETE PAPERWORK.

Revised 06 2008