



PROVIDER ORDER FORM

Selkirk Diagnostics, LLC
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Hayden, ID 83835

Phone: (208) 900-2024
Fax: (986) 226-5077

DATE: _____

PATIENT INFORMATION		
Patient Name:	DOB:	Phone #:
Pregnant: Yes No	EDD:	Email:
PHYSICIAN/PROVIDER INFORMATION		
Provider Name:	NPI #:	
Provider Fax #:	Provider Phone #:	
<input type="checkbox"/> Routine <input type="checkbox"/> STAT (Direct phone # required) <div style="text-align: right;">Call positive STAT results to:</div>		
Narrative Diagnosis/Symptoms or ICD10 Diagnosis:		

ULTRASOUND EXAM REQUESTED

<p>ABDOMEN</p> <input type="checkbox"/> ABDOMEN COMPLETE (76700) <input type="checkbox"/> ABDOMEN LMTD:(76705) RUQ, LUQ <input type="checkbox"/> RENAL COMPLETE (76770) <input type="checkbox"/> BLADDER (PVR ONLY) (76857) <input type="checkbox"/> HERNIA (SITE:) <input type="checkbox"/> APPENDIX (76705)	<p>GYNECOLOGY</p> <input type="checkbox"/> PELVIC COMPLETE(INCLUDES BOTH:) TRANSABDOMINAL (76856) TRANSVAGINAL (76830) <input type="checkbox"/> PELVIC (T/A ONLY) (76856) <input type="checkbox"/> PELVIC (TV ONLY) (76830) ___ IUD CHECK <input type="checkbox"/> FOLLICULAR TRACKING (76830)	<p>SOFT TISSUE/OTHER</p> <input type="checkbox"/> THYROID (76536) <input type="checkbox"/> SCROTUM (76870) W/DUPLEX <input type="checkbox"/> SOFT TISSUE NECK (76536) (Palpable lump) <input type="checkbox"/> SOFT TISSUE (76604) ___ CHEST ___ BACK <input type="checkbox"/> EXTREMITY (NON VASC LMTD) ___ RT ___ LT (76882)
<p>VASCULAR</p> <input type="checkbox"/> VENOUS LEGS/BILATERAL (93970) <input type="checkbox"/> VENOUS LEG (93971) ___ RT ___ LT <input type="checkbox"/> VENOUS ARMS/BILATERAL(93970) <input type="checkbox"/> VENOUS ARM (93971) ___ RT ___ LT <input type="checkbox"/> ARTERIAL LEGS/BILATERAL(93925) <input type="checkbox"/> ARTERIAL LEG (93926) ___ RT ___ LT <input type="checkbox"/> RENAL ARTERIAL (93975) <input type="checkbox"/> TRANSPLANT KIDNEY (76776) <input type="checkbox"/> AAA (76706) <input type="checkbox"/> CAROTID DUPLEX (93880)	<p>OBSTETRICS</p> <input type="checkbox"/> OB (<14 weeks) Single (76801) w/TV as needed <input type="checkbox"/> OB Transvaginal (76817) <input type="checkbox"/> OB (<14 weeks) Add Fetus (76802) <input type="checkbox"/> OB (>14 weeks) Single Complete (Anatomy) (76805) ___ Add Fetus (76810) <input type="checkbox"/> OB TRANSVAGINAL F/UP (76817) <input type="checkbox"/> OB FOLLOW UP (76816) (GROWTH, ANATOMY, AFI) <input type="checkbox"/> OB LMTD (76815) (FHT, AFI Position) <input type="checkbox"/> BPP w/out NST (76819)	<p>BREAST</p> <input type="checkbox"/> UNILATERAL BREAST (76642) (Acute symptoms) <p>BREAST SCREENING</p> <input type="checkbox"/> BILATERAL BREAST <input type="checkbox"/> UNILATERAL BREAST ___ RT ___ LT (Please fax any prior mammo report) <p>ECHOCARDIOGRAPHY</p> <input type="checkbox"/> ECHO COMPLETE (93306) <p>OTHER EXAM REQUESTED</p> <input type="checkbox"/> _____

PHYSICIAN SIGNATURE _____

Affordable Self Pay Ultrasound & Echo Imaging