

ED OUTPATIENT WORKSHEET FOR NEXT-DAY FOLLOW-UP ULTRASOUND

Patient Name: _____ DOB: _____

Diagnosis Code: _____

Exam: ☐ US OB <14 WKS W TRANSVAG
☐ US ABDOMEN LIMITED (see prep notes at bottom)
☐ US TRANSVAGINAL + US PELVIC DOPPLER LIMITED
☐ Other: _____

Comments/Special Instructions: _____

Provider Signature

Date

☐ Request Faxed to Ultrasound Department (Ext. 3750)

☐ Ultrasound Voicemail Notified (Ext. 3709)

APPOINTMENT DETAILS:

Next-day follow-up is available daily, excluding holidays

Date: ____/____/____

Time:

Day:

<input type="checkbox"/> 07:30 AMon.....	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri
<input type="checkbox"/> 08:30 AMon.....	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri
<input type="checkbox"/> 09:30 AMon.....	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun			

Patient Instructions:

IMPORTANT: Please bring this request form to your appointment.

Arrival Time: Please arrive 30 minutes before your appointment time to register.

Entrance: Mon-Fri: Please use the Outpatient Services Entrance on the south side of the hospital
Sat/Sun: Please use the Main Entrance of the hospital on Williams Street

Exam Prep: If you are having an **Abdominal Ultrasound** (Abdomen, RUQ, Gall Bladder):

- Nothing to eat or drink for 6 hours prior to your exam.
- Do not smoke, chew gum, or drink carbonated beverages.