



THE QUEEN'S MEDICAL CENTER

Women's Health Center

1329 Lusitana Street • Honolulu, Hawaii 96813 • Phone (808) 691-7555 • Fax (808) 691-7007

Scheduling Information

Name: _____ Medical Record #: _____
Last / First

Date of Birth: _____

Day Phone #: _____ Cell phone #: _____

Primary Insurance: _____

Secondary Insurance: _____

Physician Request for Ultrasound Services

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 1st Trimester Screening | <input type="checkbox"/> OB | <input type="checkbox"/> Pelvic | <input type="checkbox"/> AFI Once / Week |
| <input type="checkbox"/> Integrated Screening | <input type="checkbox"/> Amnio w/OB U.S. | <input type="checkbox"/> Sonohysterography | <input type="checkbox"/> AFI Twice / Week |
| <input type="checkbox"/> Sequential Screening | <input type="checkbox"/> Amnio Only | <input type="checkbox"/> Other | <input type="checkbox"/> NST Once / Week |
| | | | <input type="checkbox"/> NST Twice / Week |

Diagnosis / comments: _____

ICD-9 code _____

LMP _____

G _____ P _____

Blood type (for amnio) _____

Scheduled by: _____	
_____	_____
Date	Time

PHYSICIAN NAME

STREET ADDRESS

PHYSICIAN SIGNATURE

DATE