700 Highlander Blvd. Suite# 150
Arlington, TX 76015
Phone #: 817-465-VIEW (8439)
FAX #: 817-465-8438
www.ultraviewimaging.com

Physician Order for Diagnostic Ultrasound

TO: ULTRAVIEW IMAGING
RE: LEVEL ONE/ TWO ULTRASOUND

Patient Name: ____

D.O.B: ______________________ **Phone#:**______________________________

Referring Midwife/ Physician: ____

Referring Midwife/ Physician Phone#:_____________________**Fax#:**_____________

Examination Requested

Obstetrics & Gynecology

- ☐ **Fetal Anatomy Screening with Fetal Measurements**
- ☐ **Fetal Measurements ONLY**
- ☐ **Fetal Position**
- ☐ **Placenta location**
- ☐ **Amniotic Fluid Volume Check**
- ☐ **Biophysical Profiles**
- ☐ **Cervical Length Check**

Reason for Exam: ____

____

____

______________________________ ________________
Midwife/Physician Signature **Date**