Ultrasound & X-Ray

Please see instructions on back

HALŌ
BREAST CARE CENTER

1720 Esplanade
Chico, CA 95926
O: 530-898-0500
F: 530-898-0533
halobreastcare.com

Breast Imaging Center of Excellence

Patient Name: _____

Home Phone: _____ DOB: _____

Appointment Date: _____ Time: _____

Insurance: _____

Diagnosis/Reason for Exam: _____

_____ **ICD-10 Code:** _____

Please fax relevant clinical information to our office along with this order.

Ultrasound ☐ Kidney ☐ Bladder ☐ Pelvic with vaginal probe ☐ Pelvic without vaginal probe

Ultrasound ☐ Thyroid ☐ Testicular ☐ Soft Tissue *non-vascular* Area of Concern: _____

Fetal

☐ **First Trimester** LMP _____ or EDD _____

☐ **Second Trimester** Indication _____

WE do not perform nuchal translucency studies AT THIS TIME

Special Instructions _____

☐ **Third Trimester** ☐ **Endovaginal sonography can be performed if indicated by radiologist***

Abdominal Ultrasound *Please check appropriate exam below:*

☐ **RUQ** *liver, gallbladder, pancreas, aorta, right kidney* ☐ **LUQ** *spleen, left kidney* ☐ **Complete** *(RUQ & LUQ)* ☐ **Aorta**

Hernia Study Indication _____

Vascular Ultrasound *Please check appropriate exam below:*

☐ **Carotid** Special Instructions _____

☐ **Doppler Ultrasound**

☐ Extremity Venous Doppler (DVT) ____R ____L and ____Arm ____Leg

☐ Liver Doppler ☐ Renal Artery Doppler ☐ Pseudoaneurysm

Digital X-Ray

☐ SKULL ☐ SINUS ☐ X-RAY / OTHER

☐ ORBITS ☐ CERVICAL SPINE

☐ SHOULDER ○ Left ○ Right ○ Both

☐ HUMERUS ○ Left ○ Right ○ Both

☐ CHEST ☐ THORACIC SPINE

☐ RIBS ○ Left ○ Right ○ Both

☐ ABDOMEN COMPLETE ☐ SACRUM / COCCYX

☐ KUB ☐ LUMBAR SPINE

☐ ELBOW ○ Left ○ Right ○ Both

☐ FOREARM ○ Left ○ Right ○ Both

☐ WRIST ○ Left ○ Right ○ Both

☐ HAND ○ Left ○ Right ○ Both

☐ FINGER ○ Left ○ Right ○ Both

☐ HIP ○ Left ○ Right

☐ PELVIS / BILATERAL HIPS

☐ FEMUR ○ Left ○ Right ○ Both

☐ KNEE ○ Left ○ Right ○ Both

☐ TIBIA/FIBULA ○ Left ○ Right ○ Both

☐ ANKLE ○ Left ○ Right ○ Both

☐ FOOT ○ Left ○ Right ○ Both
(Non-Weight Bearing ONLY)

☐ TOE ○ Left ○ Right ○ Both

☐ CALCANEUS ○ Left ○ Right ○ Both

☐ SCOLIOSIS ☐ BONE AGE SURVEY

❑ HALO Hereditary Cancer Gene Panel

Test descriptor and intended/appropriate use: The HALO Hereditary Cancer Gene Panel is a comprehensive analysis of 23 genes (APC, ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CDKN2A, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, NF1, ALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, and TP53) associated with hereditary cancer predisposition and is intended to be used for patients who are at increased risk for a pathogenic variant based upon personal or family history of cancer.

Referring Provider Name (Please Print): _____ Date: _____

Referring Provider Signature: X _____ CC: _____

Please FAX Form to: 530-898-0533 • Important patient information on back.

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BREAST CARE CENTER

PATIENT INSTRUCTIONS

Please bring this referral slip (order), insurance card, and photo ID to your appointment.

Examination Instructions/Preparations: Some exams require preparation prior to your appointment. Please check the prep instructions below for the exam you are having. Patients who are improperly prepared for their exam may need to be rescheduled.

ULTRASOUND (Kidney, Bladder, Fetal, Pelvic): Drink 1 quart of water 11/2 hours prior to appointment, finishing 1 hour prior to appointment. Do not urinate.

ULTRASOUND (Abdomen, Aorta): Take nothing by mouth after midnight.

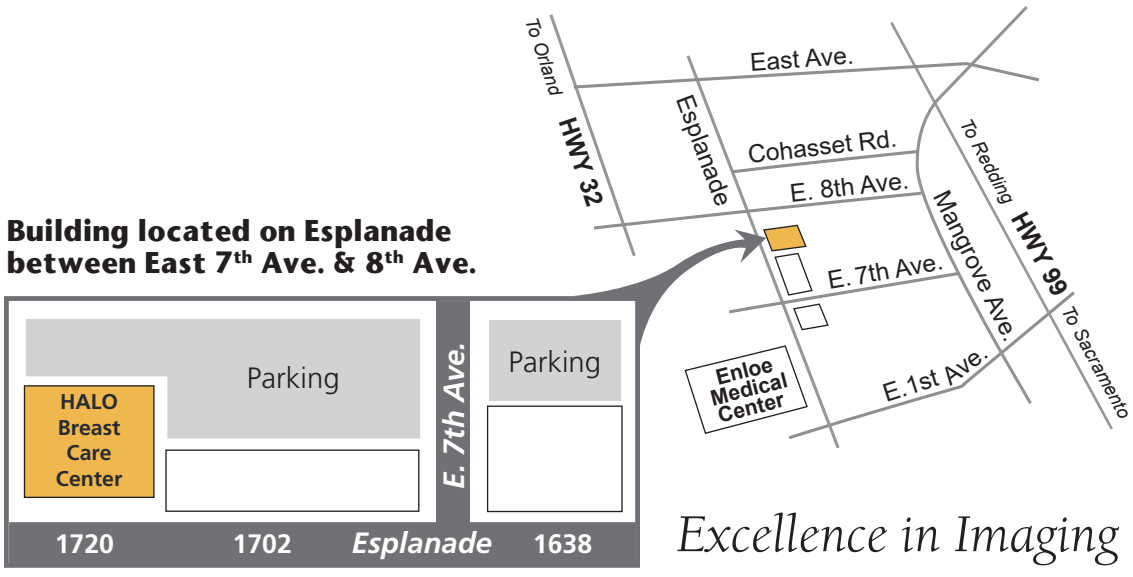
ULTRASOUND (Thyroid): Please wear a shirt with a low neckline or that opens in front if possible.

VASCULAR ULTRASOUND: Please do not use lotion or powder on the day of your exam.

- **Renal Artery Doppler:** Take nothing by mouth after midnight. Please allow 11/2 hours for exam.
- **Aorta/Illiac/Abdominal Doppler:** Take nothing by mouth after midnight.

For questions, please call our center at 530-898-0500.
To pre-register for exams, to get results and other information, please register and log in to our patient portal at www.halobreastcare.com/patient/portal/

Building located on Esplanade between East 7th Ave. & 8th Ave.



Excellence in Imaging