Radiology Requisition (Ultrasound)
Fax to: 203-848-1777

Dr. David I. Robbins
Radiology of Greater New Haven
1952 Whitney Avenue | Hamden, CT 06517
p. 203.848.1708

RADIOLOGY
of Greater New Haven

Patient Information

Patient Name: _____ Date of Birth: _____ Patient Phone: _____

Physician: _____ Phone: _____ Appointment Date and Time: _____

Insurance Information:

Provider: _____ Member ID #: _____ Member D.O.B: _____

Co-pay Amount: _____

Please note: Blue Cross members require pre-authorization for Echocardiogram studies.

ULTRASOUND **(Please Indicate Right/Left/Bilateral Study Ordered)**

X	Ultrasound Study	X	Vascular Study
	Abdomen ☐ w/Doppler		Arterial Doppler
	Aorta ☐ w/Doppler		Ankle Brachial Indices (ABI)
	Breast ☐ R ☐ L ☐ Bilat.		Arterial Upper Ext. ☐ Bilat.
	Echocardiogram		Arterial Lower Ext. ☐ Bilat.
	Pelvic ☐ w/Doppler ☐ Transvaginal		Carotid
	Renal ☐ w/Doppler		Transthorasic Resting Echocardiogram
	Scrotal		Venous Upper Ext. ☐ Bilat.
	Thyroid		Venous Lower Ext. ☐ Bilat.
			Venous Doppler
X	**Non-Vascular Study**		Venous Mapping
	Upper Extremity ☐ R ☐ L ☐ Bilat.		
	Lower Extremity ☐ R ☐ L ☐ Bilat.	**X**	**Other (please specify below):**

Patient Instructions:

☐ Nothing by mouth after midnight (includes chewing gum/smoking)

☐ Drink 32oz of water. Finish drinking one hour prior to exam. DO NOT urinate before exam time.

☐ Wear a comfortable, two-piece outfit.

☐ Do not wear any deodorant, talcum powder or perfume on breast or under-arm area.