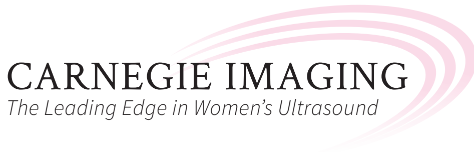

☐ **CARNEGIE SOUTH** (Between 31st & 32nd)
148 Madison Ave. 10th Fl | New York, NY 10016
Main: (212) 427-1576 | **Fax:** (212) 348-3613

☐ **CARNEGIE HILL** (Between 89th & 90th)
1245 Madison Avenue | New York, NY 10128
Main: (212) 722-7426 | **Fax:** (646) 525-3685

Name: ______________________ **Date:** ______________ **LMP:** ______________

Referring Provider: ______________________ **Gravida:** ______________ **Parity:** ______________

Medications: ____

ULTRASOUND INDICATIONS
(Check all that apply)

- ☐ Postpartum bleeding
- ☐ Pelvic pain
- ☐ Pelvic masses
- ☐ R/O polycystic ovaries
- ☐ Dysmenorrhea (painful menses)
- ☐ Amenorrhea
- ☐ Abnormal bleeding
- ☐ Monitoring of infertility patients, (follicle count)
- ☐ Evaluation in the presence of a limited clinical examination of the pelvis (eg. obesity)
- ☐ H/O uterine fibroids
- ☐ Dyspareunia
- ☐ R/O pelvic infection
- ☐ Characterization of a pelvic abnormality noted on another imaging study (eg. MRI/CT)
- ☐ Evaluation of congenital uterine anomalies
- ☐ Localization of an intrauterine contraceptive device
- ☐ Screening for malignancy in high-risk patients
- ☐ Evaluation of incontinence or pelvic organ prolapse
- ☐ Other ______________________________

RELEVANT PAST SURGICAL HISTORY

- ☐ Prior cesarean section
- ☐ Prior laparoscopy
- ☐ Prior hysterectomy (☐total or ☐subtotal)
- ☐ Prior Myomectomy
- ☐ Prior ovarian cystectomy (☐L ☐R ☐B)
- ☐ Prior oophorectomy (☐L ☐R ☐B)
- ☐ Other ______________________________

GYN ULTRASOUND

- ☐ GYN ultrasound (Doppler as indicated)
- ☐ GYN ultrasound - TA only
- ☐ GYN ultrasound - transrectal*
- ☐ GYN ultrasound with 3D

GYN PROCEDURES

- ☐ Saline Infusion Sonogram (Day 5-9 of cycle for procedure)
- ☐ Double Balloon catheter treatment of Cesarean Scar Pregnancy (CSP)*
- ☐ Percutaneous injection of Ectopic pregnancy (CSP or Cornual)*
- ☐ Adnexal Cyst Aspiration (case by case basis – please call Carnegie MD to discuss prior to arranging procedure)*
- ☐ Other* ______________________________

***Please call Carnegie MD's to discuss prior to arranging procedure**

Provider Signature: ____