



## MSK ULTRASOUND REFERRAL FORM

Please bring this form with you. We cannot perform any exam without it.

### Patient & Referring Physician Details

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Patient Phone \_\_\_\_\_

Referring Physician (Print) \_\_\_\_\_ Physician Phone \_\_\_\_\_

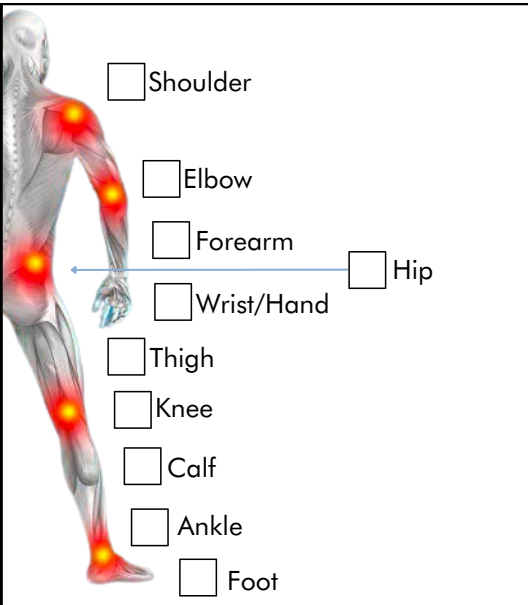
Physician Signature \_\_\_\_\_ Order Date \_\_\_\_\_

CC: \_\_\_\_\_

### Clinical Indications / Diagnosis

Must be filled in for exam to be performed:

### Special Instructions



**Comprehensive Referral:** Diagnostic Ultrasound with aspiration/injection if indicated \*\*\* (MAY REQUIRE PRIOR AUTHORIZATION)

<b>Diagnostic Ultrasound:</b> (CPT 76881)	<b>Check all that apply:</b> <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Tendon <input type="checkbox"/> Joint <input type="checkbox"/> Muscle <input type="checkbox"/> Nerve Other: _____
<b>Side:</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<b>Location:</b>	<input type="checkbox"/> Lateral <input type="checkbox"/> Medial <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior (For hand): <input type="checkbox"/> Palmar <input type="checkbox"/> Dorsal <input type="checkbox"/> Radial <input type="checkbox"/> Ulnar (For feet): <input type="checkbox"/> Plantar <input type="checkbox"/> Dorsal
<b>Special Instruction:</b>	_____

	Procedures	CPT
<b>Aspiration/Injections</b>	Hand/Foot Joints	20604
	Elbow, Ankle, Wrist	20606
	Knee, Shoulder, Hip	20611
	Ganglion Cyst Aspiration Injection	20612
	Tendon Sheath Injection	20550
	Irrigation Calcific Tendonopathy	20611
	Morton Neuroma Alcohol Ablation	64632
	Tendon Injection	20551
	Tenotomy (Needle fenestration Tendon)	24357
	Nerve Injection	64450
	Muscle/ Soft Tissue Biopsy	20206

<b>Procedures:</b> *** (May require Prior Authorization) ***	<b>Check all that apply:</b> <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Tendon <input type="checkbox"/> Tendon Sheath <input type="checkbox"/> Joint <input type="checkbox"/> Muscle <input type="checkbox"/> Nerve <input type="checkbox"/> Ganglion Cyst <input type="checkbox"/> Bursa Special Instruction: _____
<b>Side:</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<b>Location:</b>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist/Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot
<b>Procedures:</b>	<input type="checkbox"/> Steroid Injection <input type="checkbox"/> Aspiration <input type="checkbox"/> Morton Ablation <input type="checkbox"/> Tenotomy <input type="checkbox"/> Irrigation Calcific Tendonopathy <input type="checkbox"/> Tendon Sheath Injection
<b>Imaging Guidance:</b>	<input type="checkbox"/> Ultrasound Guided (Pasadena, West Covina and Cordova) <input type="checkbox"/> Fluoroscopic Guided (West Covina only)