DIAMOND
Interventional Center

ULTRASOUND REFERRAL FORM

Patient Name: _____

Patient DOB: _____

Patient Address: _____

Patient Phone: _____

Patient Insurance: _____

Referring Physician / Facility: _____

Phone Number: _____

Fax Number: _____

Reason for Referral: _____

Signs & Symptoms: _____

_____

Type of Ultrasound:

[ ] Carotid	[ ] Upper Venous	[ ] Upper Arterial	[ ] Renal
[ ] Lower Arterial	[ ] Lower Venous	[ ] Vein Mapping	[ ] Thyroid
[ ] Liver	[ ] Abdomen	[ ] Ascites	[ ] Bladder
[ ] Renal Artery	[ ] Echocardiogram	[ ] Pelvic	[ ] Fistula

Please Attach Patient:
Demographic Sheet, Recent H&P, Diagnostic Images, Labs (including coagulation), Medication List, Insurance Cards.

Phone: 816-647-0555
Fax: 816-203-4305
3600 NE Ralph Powell Rd Suite A
Lee's Summit, MO 64064

Thank You For The Opportunity To Participate In Your Patient's Health Care