Methodist Le Bonheur Healthcare

Methodist University Hospital
Ultrasound Department
Phone: 901-516-7129
Fax: 901-516-2132

(Place Patient Identification Sticker Here)

Contrast Ultrasound Request Form

Patient Name _____DOB _____

MRN _____Date/Time _____

Ordering Physician _____Phone Number _____

Indication:

☐ Liver Lesion ☐ Right Renal Lesion ☐ Left Renal Lesion

Prior Imaging of Lesion:

☐ CT Where: _____When: _____

☐ MRI Where: _____When: _____

☐ U/S Where: _____When: _____

If imaging was performed outside of Methodist, the imaging disk must be submitted to radiology for review prior to approval.*

Reason for Needing a Contrasted Ultrasound Exam:

☐ Patient cannot receive CT/MRI contrast.

- ☐ Renal Insufficiency _____
- ☐ Contrast Allergy _____

☐ Other _____

***any lesion for which a contrast ultrasound is to be scheduled must be imaged previously.**