



Cambridge Health Alliance

Department of Radiology

Ultrasound Imaging Service

Scheduling 617-665-1298

OB/GYN Ultrasound Imaging Requisition

Name: _____ DOB: _____

MRN: _____

Date and Time of Appointment: _____

- Location:
- Cambridge Hospital Campus**
1493 Cambridge St. Cambridge, MA 02139; Tel.: 617-665-1000 Fax order to 617-665-1649
 - Somerville Hospital Campus**
230 Highland Avenue, Somerville, MA 02143; Tel.: 617-591-4500 Fax order to 617-591-4166
 - Whidden Memorial Hospital Campus**
103 Garland St. Everett, MA 02149; Tel.: 617-389-6270 Fax order to 617-394-7644

- Early OB Ultrasound with f/u as recommended
- OB Survey with f/u as recommended
- High Risk Ultrasound
- Third Trimester OB
- Biophysical Profile
- Amniotic Fluid Index
- Pelvic Ultrasound
- Transvaginal as indicated
- Hysterosonogram
- Amniocentesis

Clinical History/Diagnosis: _____

Ordering provider _____ Phone/Beeper # _____

**PLEASE HAVE PATIENT BRING THIS FORM AT TIME OF EXAM AND FAX A COPY.
THE EXAM WILL NOT BE PERFORMED WITHOUT A COPY OF THIS ORDER!**