



CAPITOL IMAGING

"Where Making a Difference Matters"

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DIAGNOSTIC ULTRASOUND | REFERRAL

PATIENT INFORMATION:

Full Name:

Date of Birth: ____ / ____ / ____ Gender: Male Female

Address: _____

Phone Number: _____ E-Mail: _____

Insurance Information:

PROVIDER INFORMATION:

Provider Name:

Address: _____

Phone Number: _____ Fax Number: _____

Provider Signature : Date : ____ / ____ / ____

STUDY INFORMATION:

Indication:

What are we ruling out?:

(Please Specify)

Routine: STAT: ICD-10/DIAGNOSIS CODE(S):

Ultrasound Exam	CPT	Ultrasound Exam	CPT	Ultrasound Exam	CPT	Ultrasound Exam	CPT	Ultrasound Exam	CPT
<input type="checkbox"/> Abdominal Aorta Ultrasound	76770	<input type="checkbox"/> Aorta/Renal Retroperitoneal Limited	76775	<input type="checkbox"/> Pelvic Ultrasound	76856	<input type="checkbox"/> Breast Bilateral	76641	<input type="checkbox"/> Upper Extremity Arterial Unilateral R_ L_	93931
<input type="checkbox"/> Abdomen Complete	76700	<input type="checkbox"/> Carotid	93880	<input type="checkbox"/> Follicular Monitoring (Pelvic)	76856	<input type="checkbox"/> Breast unilateral R_ L_	76642	<input type="checkbox"/> Lower / Upper Extremity Venous Bilateral	93970
<input type="checkbox"/> Abdomen with Doppler	93975	<input type="checkbox"/> Thyroid	76536	<input type="checkbox"/> US Pregnancy (OB) < 12 Weeks	76801	<input type="checkbox"/> Lower Extremity Arterial Bilateral	93925	<input type="checkbox"/> Lower / Upper Extremity Venous Unilateral R_ L_	93971
<input type="checkbox"/> Abdomen Limited (including RUQ)	76705	<input type="checkbox"/> Scrotal	76870	<input type="checkbox"/> US Pregnancy (OB) > 12 Weeks	76805	<input type="checkbox"/> Lower Extremity Arterial Unilateral R_ L_	93926	Other: _____	
<input type="checkbox"/> Aorta/Renal Retroperitoneal Complete	76770	<input type="checkbox"/> Bladder	76857	<input type="checkbox"/> US Pregnancy (OB) Twins	76810	<input type="checkbox"/> Upper Extremity Arterial Bilateral	93930	Other: _____	

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CAPITOL IMAGING POLICY:

Carefully follow the instructions and if you have any questions, please call our office at least **24 hours** before your scheduled scan for better assistance.

Upon your visit to Capitol Imaging, please bring the following:

1. Form of identification
2. Insurance information/ form of payment
3. Referring physician order form

Children 18 and under **CAN NOT** be left alone or go into the exam room without a legal parent or guardian.

We do have a **10 min late policy.**

If you are more than 10 mins late OR have not followed the prepping instructions, we **WILL** reschedule our appointment.

ABDOMINAL EXAM PREPERATION:

Must be fasting.

DO NOT eat or drink anything **8 hours** before your exam.
We will reschedule if you do not fast.

OB/GYN & RENAL/BLADDER EXAM PREPERATION:

1 hour before your exam, drink 32oz. of water (about 2 water bottles).

DO NOT empty your bladder before your exam.

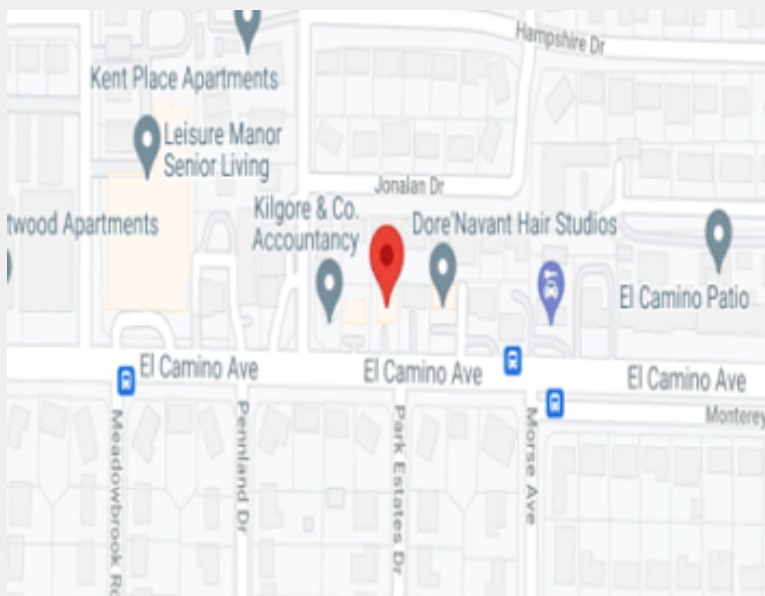
A full bladder is essential for better image quality

The Technician performing the exam will direct you to use the rest room.

VASCULAR & SMALL PARTS PREPERATION:

No special preparation is necessary.

LOCATION & HOURS:



Location:

3013 El Camino Ave Suite A
Sacramento CA, 95821

Hours:

Monday-Friday
9am-6pm

Saturday 11am-5pm

Sunday: Closed

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