

Makana North Shore Urgent Care
4488 Hanalei Plantation Rd
Princeville, Hawaii



Fax To: 808.326.4505
imaging@makanahealthcare.org

Makana North Shore UltraSound Referral Form

Please fax completed referral form with patient's demographics and insurance information.

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

Insurance: _____ Member ID: _____

Referring Provider: _____ Clinic Name: _____

Phone: _____ Fax: _____ or Email if preferred:

Requested Study

- | | |
|--|---|
| <input type="checkbox"/> Abdominal Ultrasound (Complete / Limited) | <input type="checkbox"/> Abdominal Aorta Ultrasound |
| <input type="checkbox"/> OB Ultrasound (1 st Trimester) | <input type="checkbox"/> OB (Complete >14 weeks) <input type="checkbox"/> OB Ultrasound (F/U) |
| <input type="checkbox"/> Pelvic Ultrasound | <input type="checkbox"/> Renal / Bladder Ultrasound |
| <input type="checkbox"/> Soft Tissue / Lump Evaluation | <input type="checkbox"/> Thyroid / Neck Ultrasound |
| <input type="checkbox"/> Other: _____ | |

Clinical Indication / Diagnosis

Priority: Routine Urgent

Ordering Provider Signature: _____

Date: _____