OHANA IMAGING SOLUTIONS (OIS) — ULTRASOUND REFERRAL FORM

1188 Bishop St., #1706, Honolulu, HI 96813 | Phone: (808) 752-4614 | Fax: (808) 752-4616 | Service@OIS808.com

Hours: Monday - Saturday, 8:00 AM - 5:00 PM

PATIENT INFORMATION

Name: _____DOB: _____

Phone: _____ Email: _____

Insurance / Self-Pay: _____ Member ID: _____

PCP / Referral Required? _____ Authorization # / Status: _____

ORDERING PROVIDER

Provider Name: _____ NPI: _____

Clinic: _____ Phone: _____

Fax: _____ Email: _____

[ ] **Complete Transthoracic Echocardiogram w/ Doppler & Color (CPT 93306)** and GLS/strain (CPT 93356) if clinically indicated

[ ] Routine (3-7 days) [ ] Urgent (24-72 hrs) [ ] STAT - call office

CLINICAL INDICATION - SELECT ALL THAT APPLY

Symptoms / Exam Findings

[ ] New/worsening dyspnea, orthopnea, edema
ICD: R06.02 / R60.9

[ ] Chest pain/pressure with cardiac concern
ICD: R07.9

[ ] Syncope/presyncope with cardiac concern
ICD: R55

[ ] New murmur or change in known murmur
ICD: R01.1

[ ] Palpitations/arrhythmia + ECG concern
ICD: R00.2 / I49.9

[ ] Abnormal exam: JVD, rales, cyanosis
ICD: R09.89

Known or Suspected Disease

[ ] Heart failure / CHF / EF reassessment
ICD: I50.9

[ ] Cardiomyopathy / LV dysfunction
ICD: I42.9

[ ] Known/suspected valve disease
ICD: I34/I35/I36

[ ] Pulmonary HTN / RV strain
ICD: I27.20

[ ] Pericardial effusion/pericarditis
ICD: I31.3 / I30.9

[ ] Aortic root dilation / bicuspid AV
ICD: I77.81 / Q23.1

Abnormal Testing / Surveillance

[ ] Abnormal ECG
ICD: R94.31

[ ] Elevated BNP/NT-proBNP / CHF concern
ICD: R79.89

[ ] Abnormal CXR/CT: cardiomegaly/edema
ICD: R93.1

[ ] Chemo monitoring baseline/follow-up
ICD: Z01.818 / Z51.81

[ ] Pre-op with cardiac symptoms/findings
ICD: Z01.818 + dx

[ ] Repeat echo: change or surveillance due
ICD: Prior abnormality

REQUIRED CLINICAL QUESTION: What are you asking the echo to evaluate?

Ventricular function evaluation and:

DOCUMENTATION REMINDERS

Attach recent clinical notes when available. For pre-op, repeat echo, hypertension/diabetes only, or screening requests, include symptoms, abnormal findings, known disease, or surveillance reason.

Provider Signature: _____ Date: _____

Fax completed referral + order + demographics + insurance + clinical notes to: (808) 752-4616

More referral forms: