



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

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	Known or Suspected Disease	Abnormal Testing / Surveillance
☐ New/worsening dyspnea, orthopnea, edema ICD: R06.02 / R60.9	☐ Heart failure / CHF / EF reassessment ICD: I50.9	☐ Abnormal ECG ICD: R94.31
☐ Chest pain/pressure with cardiac concern ICD: R07.9	☐ Cardiomyopathy / LV dysfunction ICD: I42.9	☐ Elevated BNP/NT-proBNP / CHF concern ICD: R79.89
☐ Syncope/presyncope with cardiac concern ICD: R55	☐ Known/suspected valve disease ICD: I34/I35/I36	☐ Abnormal CXR/CT: cardiomegaly/edema ICD: R93.1
☐ New murmur or change in known murmur ICD: R01.1	☐ Pulmonary HTN / RV strain ICD: I27.20	☐ Chemo monitoring baseline/follow-up ICD: Z01.818 / Z51.81
☐ Palpitations/arrhythmia + ECG concern ICD: R00.2 / I49.9	☐ Pericardial effusion/pericarditis ICD: I31.3 / I30.9	☐ Pre-op with cardiac symptoms/findings ICD: Z01.818 + dx
☐ Abnormal exam: JVD, rales, cyanosis ICD: R09.89	☐ Aortic root dilation / bicuspid AV ICD: I77.81 / Q23.1	☐ Repeat echo: change or surveillance due ICD: Prior abnormality

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

Ventricular function evaluation and:

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:

