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Farah B. Williams, MD
 Chief Radiologist

Diagnosis/ICD9 code required: _____ Appointment Date & Time: _____

Demographic Information
 (Please Print)

Patient Name			D.O.B.	
Daytime Phone		Other Phone		
Primary Insurance Carrier	Policy #	Group #	Phone	
Secondary Insurance Carrier	Policy #	Group #	Phone	
Referring Physician		Phone	Fax	

Breast Care

<input type="checkbox"/> Screening - Digital Mammography	<input type="checkbox"/> Diagnostic - Digital Mammography __ Right __ Left
<input type="checkbox"/> Perform diagnostic mammogram and ultrasound if necessary	<input type="checkbox"/> Perform breast ultrasound if necessary
<input type="checkbox"/> Ultrasound Breast: __ Right __ Left	<input type="checkbox"/> Fine Needle Aspiration Breast: __ Right __ Left
<input type="checkbox"/> Ductogram: __ Right __ Left	<input type="checkbox"/> Core Biopsy Breast: __ Right __ Left

Ultrasound OB/GYN

<input type="checkbox"/> OB 1 st Trimester	<input type="checkbox"/> OB 2 nd - 3 rd Trimester	<input type="checkbox"/> Saline Pelvic US	<input type="checkbox"/> Pelvic:
<input type="checkbox"/> Limited OB _____			<input type="checkbox"/> Transabdominal <input type="checkbox"/> With Endovaginal

Ultrasound General

<input type="checkbox"/> Abdomen Limited	<input type="checkbox"/> Cranial	<input type="checkbox"/> Urinary Bladder
<input type="checkbox"/> Abdomen Complete	<input type="checkbox"/> Renal	<input type="checkbox"/> Other:
<input type="checkbox"/> Aorta	<input type="checkbox"/> Prostate	_____
<input type="checkbox"/> Appendix	<input type="checkbox"/> Testicular	_____
<input type="checkbox"/> Breast: __ Right __ Left	<input type="checkbox"/> Thyroid	

Ultrasound Vascular

<input type="checkbox"/> Lower Extremity Arterial __ Right __ Left	<input type="checkbox"/> Upper Extremity Arterial __ Right __ Left	<input type="checkbox"/> Carotid	<input type="checkbox"/> ECHO
<input type="checkbox"/> Lower Extremity Venous __ Right __ Left	<input type="checkbox"/> Upper Extremity Venous __ Right __ Left	<input type="checkbox"/> Renal Arteries	

Ultrasound Guided Biopsy/FNA

Fine Needle Aspiration:	<input type="checkbox"/> Breast	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Parathyroid	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Lymph Node	<input type="checkbox"/> Soft Tissue (Fluid Collection)		

Non-Invasive Interventional Procedures

<input type="checkbox"/> Laser Ablation of Varicose Veins	<input type="checkbox"/> Injection of Spider Veins
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Special Instructions

Call patient to schedule STAT - Call Report Request patient images: disc films PACS login

Physician's Signature: _____ Date: _____