



BERMUDA HEALTHCARE SERVICES

19 THE LANE
PAGET PG 05
BERMUDA

PHONE: 441-236-2810
FAX: 441-236-5569
EMAIL: INFO@BHCS.BM
WEB: WWW.BHCS.BM

ULTRASOUND

PATIENT'S NAME _____ DATE OF REQUEST (DD/MM/YR) _____

APPOINTMENT DATE _____ TIME _____ EMAIL _____

DOB (DD/MM/YR) _____ PHONE (DAY) _____ (CELL) _____ (HOME) _____

PATIENT'S ADDRESS _____ POSTAL CODE _____

INSURANCE COMPANY _____ POLICY # _____ CERTIFICATE # _____

DOCTOR'S NAME _____ (OFFICE) _____ (CELL) _____ (EMAIL) _____

CLINICAL INFORMATION _____

DOCTOR'S SIGNATURE _____ DIAGNOSIS _____

GENERAL

- ABDOMEN (Includes: IVC, AO, PANCREAS, GALLBLADDER)
- KIDNEYS
- PELVIC/PROSTATE
- PELVIC FEMALE

SPECIAL

- BREAST
- OBSTETRIC (L.M.P) _____
- SCROTAL
- THYROID
- TRANSVAGINAL
- TRUS

VASCULAR

- CAROTID
- VENOUS DOPPLER L R ARM LEG
- ARTERIAL DOPPLER L R ARM LEG
- RENAL ARTERIAL

OTHER

X-RAY

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> CHEST | <input type="checkbox"/> LUMBAR SPINE | <input type="checkbox"/> ELBOW (L) (R) | <input type="checkbox"/> HIP (L) (R) |
| <input type="checkbox"/> SKULL | <input type="checkbox"/> SACRUM | <input type="checkbox"/> WRIST (L) (R) | <input type="checkbox"/> ABDOMEN FLAT |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> COCCYX | <input type="checkbox"/> HAND (L) (R) | <input type="checkbox"/> ABDOMEN UPRIGHT |
| <input type="checkbox"/> SINUSES | <input type="checkbox"/> PELVIS | <input type="checkbox"/> KNEE (L) (R) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> CERVICAL SPINE | <input type="checkbox"/> FEMUR | <input type="checkbox"/> ANKLE (L) (R) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> THORACIC SPINE | <input type="checkbox"/> SHOULDER (L) (R) | <input type="checkbox"/> FOOT (L) (R) | <input type="checkbox"/> _____ |

(SEE BACK FOR PATIENT INSTRUCTIONS)



19 THE LANE
PAGET PG 05
BERMUDA

PHONE: 441-236-2810
FAX: 441-236-5569
EMAIL: INFO@BHCS.BM
WEB: WWW.BHCS.BM

BERMUDA HEALTHCARE SERVICES

PATIENT INSTRUCTIONS

DO NOT WEAR A DRESS, PERFUME OR COLOGNE AND FOLLOW INSTRUCTIONS MARKED BELOW.

ULTRASOUND

ABDOMINAL ULTRASOUND *UPPER ABDOMEN*

PREP: PLEASE DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR APPOINTMENT. THE EVENING MEAL BEFORE YOUR APPOINTMENT SHOULD NOT BE FATTY. DO NOT EAT ANY FRIED FOODS FOR THAT MEAL.

PELVIC/PROSTATE **PELVIC FEMALE** **TRANSVAGINAL** **OBSTETRIC** **RENAL***

PREP: FINISH DRINKING 3 (20oz.) BOTTLES OF FLUID ONE (1) HOUR BEFORE YOUR EXAM. ARRIVE WITH A FULL BLADDER AND DO NOT GO TO THE BATHROOM UNTIL AFTER YOUR EXAM OR IT WILL NEED TO BE RESCHEDULED. (IF YOU ARE UNABLE TO HOLD OVERLY FULL BLADDER, NOTIFY FRONT DESK BEFORE YOU GO TO THE BATHROOM). ***For a renal ultrasound only a half-full bladder is required.**

ARTERIAL DOPPLER **VENOUS DOPPLER** **L** **R** **ARM** **LEG** **RENAL ARTERIAL DOPPLER**

BABY SCAN **CAROTID** **SCROTAL** **THYROID** **TRUS**

NO PREP

OTHER SPECIFY: _____

BREAST U/S

PREP: MUST BRING RECENT MAMMOGRAM FILMS AND REPORT WITH YOU. IT IS RECOMMENDED THAT YOU OBTAIN THIS INFORMATION TWO (2) DAYS IN ADVANCE OF YOUR APPOINTMENT.

ECHOCARDIOGRAPHY

PREP: NO POWDER ON CHEST AREA OR UNDER BREASTS

X-RAY

X-RAY(S)

NO PREP

OTHER SPECIFY: _____