DSP Health System

REFERRAL FORM

230-232 Independence Road
East Stroudsburg, PA 18301
(570) 420-1955 | Fax (570) 424-0707

PATIENT INFORMATION

PATIENT NAME _____ DOB _____

REFERRING DOCTOR _____ APPT. DATE _____

REFERRING DR. PHONE NO. _____ FAX _____

REASON FOR STUDY/DIAGNOSIS _____

CONTRAST: ☐ IV ☐ ORAL ☐ NONE

CONSULTATION FOR
☐ CARDIOLOGY
☐ NEUROLOGY
☐ PAIN MEDICINE
☐ PHYSICAL THERAPY

CARDIOLOGY TESTS
☐ EKG
☐ ECHOCARDIOGRAM
☐ STRESS ECHO
☐ TREADMILL STRESS TEST
☐ HOLTER MONITOR
☐ 30 DAY EVENT RECORDER

VASCULAR ULTRASOUND		
☐ VENOUS DUPLEX	☐ UE	☐ LE
☐ ARTERIAL DUPLEX	☐ UE	☐ LE
☐ CAROTID		
☐ ABDOM AORTA	☐ COMP	☐ LIM
☐ TCD	☐ COMP	☐ LIM

DIAGNOSTIC ULTRASOUND		
☐ ABDOMEN		
☐ BREAST		
☐ CHEST		
☐ KIDNEY	☐ R	☐ L
☐ PELVIS		
☐ HEAD/NECK		
☐ THYROID		
☐ SCROTUM		

ELECTROPHYSIOLOGY		
☐ ROUTINE EEG		
☐ AMBULATORY EEG	☐ 24 HR	☐ 72 HR
☐ NCV/EMG-BILAT	☐ UE	☐ LE
☐ SEP		
☐ VEP		
☐ BAEP		

SLEEP STUDY
☐ PSG-SLEEP
☐ C-PAP TITRATION
☐ OTHER: _____

MAMMOGRAM SCAN
☐ DIAGNOSTIC
☐ SCREENING

PATIENT HISTORY & SPECIAL INSTRUCTIONS:

HEAD & NECK	MRI	CT	XRAY
☐ BRAIN			
☐ INTERNAL AUDITORY CANAL			
☐ ORBITS			
☐ PITUITARY			
☐ SINUSES			
☐ TMJ ☐ R ☐ L			
☐ NECK - SOFT TISSUE			
☐ THYROID			
☐ NASOPHARYNX			
☐ BRACHIAL PLEXUS ☐ R ☐ L			

SPINE	MRI	CT	XRAY
☐ CERVICAL			
☐ THORACIC			
☐ LUMBAR			
☐ SACRAL			
☐ COCCYX			
☐ METASTATIC SCREEN - WHOLE BODY			
☐ LOCALIZED AREA:			

CHEST	MRI	CT	XRAY
☐ CHEST/THORAX			
☐ CARDIAC			
☐ OTHER: _____			

ABDOMEN/PELVIS	MRI	CT	XRAY
☐ ABDOMEN (DIAPHRAGM TO ILIAC CRESTS)			
☐ PELVIS (DIAPHRAGM TO ILIAC CRESTS)			
☐ KIDNEY			
☐ OTHER: _____			

EXTREMITIES	MRI	CT	XRAY
☐ SHOULDER ☐ R ☐ L			
☐ WRIST ☐ R ☐ L			
☐ HAND ☐ R ☐ L			
☐ ARM ☐ R ☐ L			
☐ FOREARM ☐ R ☐ L			
☐ HIP ☐ R ☐ L			
☐ KNEE ☐ R ☐ L			
☐ ANKLE ☐ R ☐ L			
☐ FOOT ☐ R ☐ L			
☐ THIGH ☐ R ☐ L			
☐ LEG ☐ R ☐ L			
☐ OTHER: _____			

ANGIOGRAPHY	MRI	CT	XRAY
☐ BRAIN/ CIRCLE OF WILLIS			
☐ NECK/CAROTID			
☐ CHEST			
☐ AORTA ABDOMEN THORACIC			
☐ PELVIS			
☐ UPPER EXTREMITY			
☐ LOWER EXTREMITY			
☐ RENAL ARTERY			
☐ PUMONARY EMBOLISM			
☐ HEART CORONARY			
☐ OTHER: _____			

PHYSICIAN SIGNATURE _____ DATE _____