KRYSTAL CLEAR
IMAGING

Ultrasound Referral Form

Patient First Name _____ Patient Last Name _____

Patient DOB _____ Patient Phone Number _____

Patient Email _____ Referring Provider _____

Patient insurance information _____

Exam(s) Requested:

_____

_____

_____

Exam Indication/ICD Code:

_____

_____

_____

Other Pertinent Information

_____

Printed Physician Name _____

Physician Signature _____ Date _____

Fax Number _____ Phone Number _____

Send Copy of Results To _____

Fax Number _____ Phone Number _____

Attention all patients: Please arrive 10 minutes early before appointment to register. Bring a copy of your insurance card, ID and doctors order. If you arrive 10 minutes past your scheduled exam time you will be asked to reschedule your appointment. A No-Show fee of $25 will be billed to you if you do not give at least a 24 hour notice prior to cancellation of your appointment. All co-pays, co-insurance, deductibles, and outstanding balances are due upon arrival.

Krystal Clear Imaging

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505-422-8306