Scheduling: 962-7900
Fax To: (833)965-0104

Last Name:	First Name:	MI:
Birthdate:	SS #:	
Phone Number (Home):	(Work):	
Appointment Time:	Appointment Date:	Check in time in Admissions:

PHYSICIAN ORDER FOR OUTPATIENT BREAST IMAGING

DIAGNOSIS/SYMPTOMS	CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)	
		☐ *Page when results are available*	Fax results to:

DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	**Order may be modified at the discretion of the Radiologist.**
	PHYSICIAN'S SIGNATURE		☐ Please notify physician if order is modified.

BREAST IMAGING

NOTE: Please circle exam.

Screening Mammogram: *no new problems*

☐ *Breast implants*

Please select an indication for exam.

Diagnostic Mammogram ☐ *Breast implants*		
Bilateral	R	L

Breast sonogram			
To follow mammo if needed	Bilateral	R	L

- ☐ Pain
- ☐ Breast discharge
- ☐ Questionable lumps

Location:

☐ History of the following: *(Circle one)*

- *Breast Cancer*
- *Lymphoma*
- *Metastatic disease*
- *High risk lesion*

☐ Other

Breast Needle Localization

Mammography Guided	Ultrasound Guided	Radiologist discretion
Bilateral	R	L

Galactogram/Ductogram	Bilateral	
Ultrasound guided biopsy		
Ultrasound guided cyst aspiration	R	L

Previous mammograms need to be available for comparison. Please ask patient to bring outside films to appointment.

Other: