



Scheduling: 962-7900
 Fax To: 962-7637

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 <input type="checkbox"/>	
			Fax results to:	
DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	Order may be modified at the discretion of the Radiologist. <input type="checkbox"/> Please notify physician if order is modified.	
	PHYSICIAN'S SIGNATURE			

NOTE: Please circle exam.

Screening Mammogram: no new problems

Breast implants

Please select an indication for exam.

Diagnostic Mammogram <input type="checkbox"/> Breast implants			<input type="checkbox"/> Pain <input type="checkbox"/> Breast discharge <input type="checkbox"/> Questionable lumps Location: <input type="checkbox"/> History of the following: <i>Breast Cancer (Circle one)</i> <i>Lymphoma</i> <i>Metastatic disease</i> <i>High risk lesion</i> <input type="checkbox"/> Other
Bilateral	R	L	
Breast sonogram			
To follow mammo if needed	Bilateral	R	

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.

BREAST IMAGING

Other: