

# MAMMOGRAPHY ORDER FORM

Patient's Name _____		Physician's Name <i>(Please Print)</i> _____	
Medical Record # _____	Phone / Fax _____	Clinic Code _____	
Date of Birth _____	SS # _____	Clinic Location _____	

**SCREENING MAMMOGRAM** - Patient with no symptoms

Bilateral

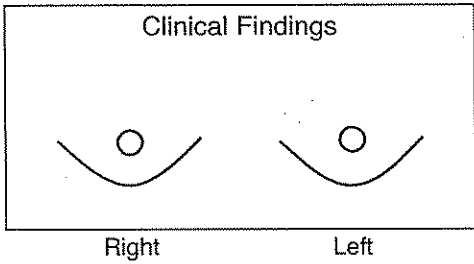
Date of last screening \_\_\_\_\_

Pregnant? Yes No

**DIAGNOSTIC MAMMOGRAM**      Urgency:       Stat (Call)       Same Day (Call)       Routine

Bilateral     Unilateral R     Unilateral L

- |   |                               |                                |
|---|-------------------------------|--------------------------------|
| <input type="checkbox"/> Change in color or surface of Breast or Nipple | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Nipple Discharge                               | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Focal Pain, constant pain.                     | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Palpable Mass or Lump                          | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Personal History of Breast Cancer.             |                               |                                |
| <input type="checkbox"/> Follow-Up of Suspicious Mass or Lesion.        |                               |                                |
| <input type="checkbox"/> Metastasis (Unknown Primary)                   |                               |                                |
| <input type="checkbox"/> Abnormal Mammographic Finding                  |                               |                                |
| <input type="checkbox"/> Implants (Breast Augmentation)                 |                               |                                |



**Multiple Procedure Referral**  
(Bring Most Recent Prior Outside Films, if Any)

Diagnostic Mammogram     Bilateral     Left     Right

With the following additional procedures, if indicated:

- Breast Ultrasound (if indicated)
- Fine Needle Aspiration (if indicated)
- Cyst Aspiration (if indicated)
- U/S Core Biopsy (if indicated)
- Stereotactic Core Biopsy (if indicated)
- Read Outside Films (if indicated)
- Micro Clip placement (Pt. on Chemo, if indicated)
- Ductogram (if indicated)
- MRI (if indicated)

**Single Procedure Referral (check one)**  
(Bring Most Recent Prior Outside Films, if Any)

Diagnostic Mammogram     Bilateral     L     R

Breast Ultrasound

Fine Needle Aspiration

Cyst Aspiration

U/S Core Biopsy

Stereotactic Core Biopsy

Read Outside Films for second opinion

Micro Clip placement

Ductogram

Wire localization

<p align="center"><b>PATIENT HISTORY</b></p>	<p align="center"><b>FOR CODER USE ONLY</b></p> <p>ICD9 CODE _____</p>
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All diagnostic, multiple procedure referrals are intended for up to five (5) visits occurring in up to 30 (thirty) days

Physician's Signature \_\_\_\_\_ Provider # \_\_\_\_\_ Phone/Pic # \_\_\_\_\_ Date \_\_\_\_\_  
(Original Signature required MD, DO, NP, PA)

Attending Physician (Please Print) \_\_\_\_\_ Attending ID # \_\_\_\_\_

- Please bring this form (completed and signed by your physician) and your insurance card with you to the Hospital or Clinic. Arriving without this form signed by your physician may result in cancellation or delay of your test.
- It is your responsibility to call your insurance company **prior** to your scheduled test date, to check coverage and see if you need a referral or pre-certification. Your insurance plan may consider your test / procedure as a screen or non-covered service.

**To Schedule an Appointment Fax Orders to Centralized Scheduling**  
**Fax # (404) 616-5090 / Phone (404) 616-5800**  
**Please Instruct Patients to Bring Most Recent Prior Outside Films**

*Please Attach Label*