BREAST IMAGING REFERRAL

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Today's Date ____________________

PATIENT NAME ___________________________________ DOB _________________ WRAD MRN ______________

APPOINTMENT DATE ______________________ TIME ___________ PATIENT PHONE __________________________

PROVIDER SIGNATURE _____________________________ PROVIDER PRINTED NAME ___________________________

SCREENING EXAMS

☐ SCREENING MAMMOGRAM (Routine exam only – No current problems)

☐ Additional views, if recommended by radiologist, to include mammogram imaging & breast ultrasound

☐ Proceed to scheduling/performing biopsy if clinically indicated by the radiologist

DIAGNOSTIC EXAMS

☐ COMPREHENSIVE DIAGNOSTIC MAMMOGRAM (includes breast US and/or biopsy if recommended by radiologist)

☐ Bilateral ☐ Left ☐ Right

INDICATION: * Selecting one of the options below automatically converts a screening exam to a diagnostic exam. *

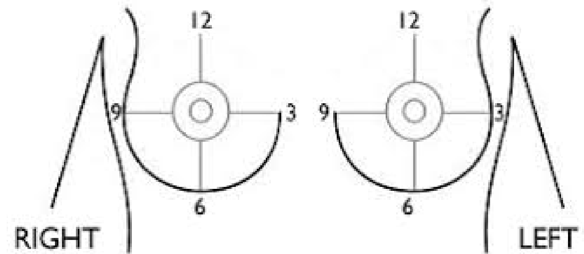
☐ Nodule ☐ Localized Pain ☐ Nipple Discharge ☐ History of Breast Cancer (within the last 5 years)

☐ Abnormal Prior Mammogram (follow-up recommended)

☐ Other, ____

*** REQUIRED***

MARK LOCATION OF INDICATED PROBLEM



ULTRASOUND EXAMS

☐ Breast Ultrasound, if indicated ☐ Bilateral ☐ Left ☐ Right

☐ Ultrasound of the axilla ☐ Bilateral ☐ Left ☐ Right

☐ US-Guided Core Needle Biopsy/US-Guided, Vacuum-Assisted Core Needle Biopsy with post-procedure mammogram for marker placement/FNA, if indicated ☐ Bilateral ☐ Left ☐ Right

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