EMORY HEALTHCARE | The frontline of care. The forefront of discovery.

Emory Hospital Perry & Emory Hospital Warner Robins
Preregistration Phone # 404-251-1239
For appointment please call 404-778-PINK (7465)
Fax: 478-542-7928

Medical Record Number: _____
Patient Name: _____
Date of Birth: _____
Sex: ◯Female ◯Male Pregnant? ◯Yes ◯No
Insurance Plan: _____
FSC #: _____ Insur Member #: _____
Referral #: / Precert #: _____
***Required** if exam to be done within 4 days of order*

Required information to schedule
Ordering MD Name (Print): _____
Office Phone: _____ Fax: _____
UPIN #: _____ (non TEC physicians)
Patient (Home): _____
Work: _____ Cell: _____

☐ **SCREENING MAMMOGRAM** (patient is having no problems; routine exam)
◯Bilateral ◯Left ◯Right **ICD Code(s):** Z12.31_____

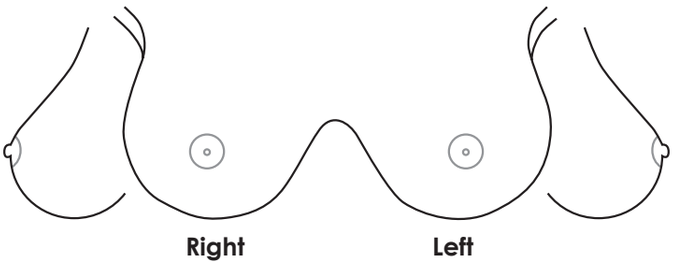
OR

DIAGNOSTIC BREAST IMAGING (patient has current problem) -- ***Order* MUST *specify signs/symptoms of concern and exact location or patient* WILL NOT BE SCHEDULED**

◯Left ◯Right ◯Bilateral **ICD Code(s):** _____

Specify Clinical Concern/Findings: _____

- ☐ Palpable mass or lump
- ☐ Skin or nipple findings.
- ☐ Nipple discharge.
- ☐ Focal pain or breast tenderness, unrelated to menses.
- ☐ Follow-up of prior finding/biopsy/lumpectomy.
- ☐ Abnormal mammographic finding/recall.
- ☐ Metastasis (unknown primary).



Required_____o'clock **OR**_____quardant

☐ **COMPREHENSIVE REFERRAL REQUEST:** Checking this box authorizes Breast Imaging Physicians to schedule additional breast related studies without separate order, to streamline patient care. You may opt out of this by choosing an individual study or combination of studies below.

OR

☐ **SINGLE STUDY REFERRAL:** **Individual order for each study is required to proceed**

☐Mammogram *specify site:* _____
☐Breast Ultrasound *specify site:* _____
☐Breast MRI ***Indication:*** _____
☐Fine Needle Aspiration *specify site:* _____
☐Cyst Aspiration *specify site:* _____
☐ Wire Localization *specify site:* _____
☐ Clip Placement only *specify site:* _____
☐ Read Outside films for second opinion
☐Core Biopsy: ☐Ultrasound guided ☐Stereotactic guided ☐MRI - guided *specify site:* _____
☐Contrast Enhanced Mammogram

Physician Signature: _____ (MD, DO, NP, PA) **Date:** _____ **Time:** _____
Scheduled Date: _____ Scheduled Time: _____ AM / PM Location (Circle) **EHWR** **WPAV** **EHP**