



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 _____ quadrant

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

<input type="checkbox"/> Mammogram	specify site: _____	<input type="checkbox"/> Wire Localization	specify site: _____
<input type="checkbox"/> Breast Ultrasound	specify site: _____	<input type="checkbox"/> Clip Placement only	specify site: _____
<input type="checkbox"/> Breast MRI	Indication: _____	<input type="checkbox"/> Read Outside films for second opinion	
<input type="checkbox"/> Fine Needle Aspiration	specify site: _____		
<input type="checkbox"/> Cyst Aspiration	specify site: _____		
<input type="checkbox"/> Core Biopsy:	<input type="checkbox"/> Ultrasound guided <input type="checkbox"/> Stereotactic guided <input type="checkbox"/> MRI - guided	specify site: _____	

Physician Signature: _____ (MD, DO, NP, PA) **Date:** _____ **Time:** _____
 Scheduled Date: _____ Scheduled Time: _____ AM / PM Location (Circle) **EUH EUHM ESJH EJCH**