

EMORY HEALTHCARE

Scheduling Line (478) 329-3200

Scheduling Fax (855) 255-8060

BREAST IMAGING ORDER FORM

Emory Healthcare Diagnostics Emory Healthcare- Warner Robins Emory Healthcare- Perry

(*) Indicates required information to schedule procedure

*Patient Name: _____ *DOB: _____ *Appt. Date: _____ Time: _____

*Primary Phone Number: _____ Email: _____

*Referring Physician: _____ Scheduler: _____

*Phone: _____ *Fax: _____

*Diagnosis: _____ Date/Location of Last Mammogram: _____

*Primary Insurance: _____ *Group: _____ *ID: _____

*Secondary Insurance: _____ *Group: _____ *ID: _____

~ MAMMOGRAPHY ~

Bilateral Screening Mammogram

Screening mammograms are used for asymptomatic women as a screening tool for the early detection of breast cancer. The following diagnoses are used for screening mammogram orders.

- No symptoms, routine, fibrocystic changes, family history of breast cancer, breast implants, diffuse breast pain

X I authorize Houston Healthcare to proceed with diagnostic mammogram and/or breast ultrasound if indicated.

Diagnostic Mammogram **Right** **Left** **Bilateral**

Diagnostic mammograms are performed for women with any but not limited to the following symptoms.

- Personal history of breast cancer, palpable lump or mass, focal pain (please specify location), nipple discharge, 6 month follow-up, 6 month follow-up post biopsy, stereotactic biopsy, abnormal screening mammogram

~ BREAST ULTRASOUND/ MRI ~

Breast Ultrasound **Right** **Left** **Bilateral**

Breast ultrasounds are used to further evaluate any abnormal breast symptoms. Please specify the area of interest.

- Palpable lump or mass or breast thickening, abnormal mammogram

X Breast MRI **Bilateral**

Breast MRI is used to further evaluate abnormal breast symptoms. This exam is always performed bilaterally using IV contrast.

- Personal history of breast cancer, rule out ruptured implants, inconclusive mammogram and breast ultrasound

~ BREAST BIOPSY ~

X Ultrasound Guided Breast Biopsy **Right** **Left** **Bilateral**

X Stereotactic Guided Breast Biopsy **Right** **Left** **Bilateral**

Ordering Physician Signature: _____ Date: _____

Only test approved by the Centers for Medicare & Medicaid Services deemed medically necessary for the diagnosis and treatment of a Medicare or Medicaid patient will be reimbursed. Test performed in the absence of signs, symptoms, complaints, diagnosis, or personal history of the disease or injury is not covered except for preventative screening tests covered by Medicare or Medicaid. Medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the federal False Claims Act and/or the State False Medicaid Claims Act.