

**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

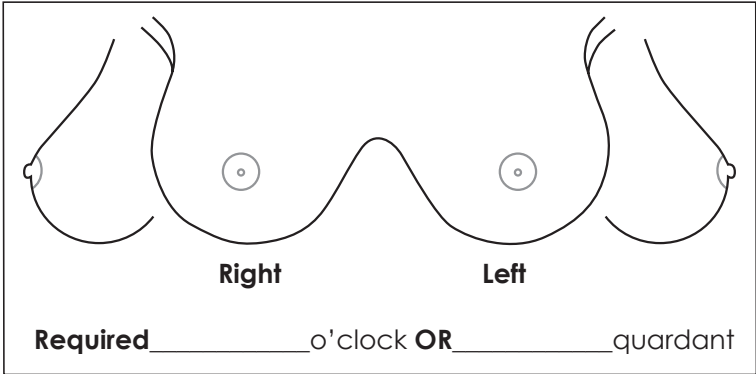
**OR**

**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**

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

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