

REQUEST FOR MAMMOGRAPHY SERVICES



Ordering care provider _____

Date _____

Copy of report to _____

Patient's name _____ DOB _____

*Best daytime phone number to contact patient _____ Alternate _____

*Best week day and/or time for scheduling appointment _____

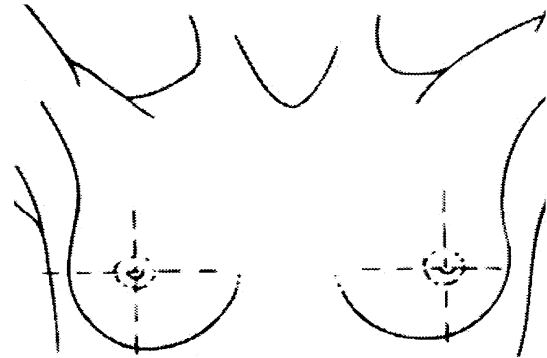
Date last clinical breast exam was performed _____

Mammogram requested

Screening mammogram

() Bilateral () Unilateral [Left/Right] () Implants

Diagnostic mammogram **Ultrasound**



Right Breast Left Breast

Indication

Lump (use diagram to mark location)

Pain (use diagram to mark location)

Skin change

Nipple discharge [Right / Left]

Other _____

Required Provider's Signature

Breast history (mark circles that apply)

Mastectomy [Right / Left] Lumpectomy [Right / Left] Benign Biopsy Family members with breast cancer

Is a language interpreter needed for this patient? _____

Does this patient have special needs (i.e. hearing or vision impaired, wheelchair use)? _____

PLEASE ADVISE YOUR PATIENT OF THE FOLLOWING:

- . Refrain from wearing deodorant, lotions and/or powders to appointment
- . Small children must be attended by an adult while patient is receiving diagnostic services
- . Please bring photo ID and insurance cards for check-in process

Please fax this form to 'Ohana at (509) 249-5319

Appointment scheduled on _____ Date _____ Time _____