



Beaufort Memorial HOSPITAL

MAMMOGRAM/DEXA SCAN REFERRAL FORM Page 1 of 1

This request for service must accompany the patient at the time of service.

Elective Routine Urgent Emergency within 24 hours Pt Acct #: _____

PATIENT INFORMATION

Patient Name (Last, First, MI): _____

Address: _____

DOB _____ Patient SS# _____ Sex M F

GENERAL INSTRUCTIONS

All orders must include an ICD-9 code or diagnosis. Tests not covered by that code, may be charged to the patient. Please fill in the appropriate code or diagnosis for each test.

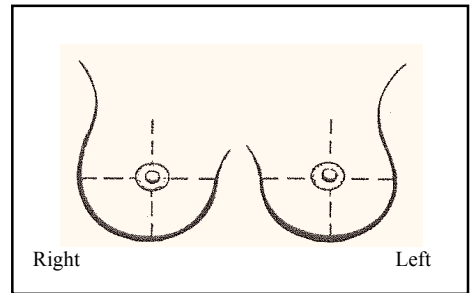
Diagnosis: (required) _____

ICD-9 Code(s) _____

*****Please specify exam or procedure desired including clinical indicators*****

Clinical Indicators Right Left Bilateral

- Abnormal Mammogram
- Short Term Follow-Up Mammogram (previous abnormal breast imaging)
- Personal History of Breast Cancer
 - Post Lumpectomy
 - Post Mastectomy
- Focal Breast Pain
- Breast Lump/Mass
- First Degree relative with Breast Cancer



Please use diagram to illustrate any clinical concerns or abnormality

Screening Mammography

Screening Mammogram - asymptomatic patient with no personal history of breast cancer.

Diagnostic Breast Evaluation (May include mammography, ultrasound and MRI as indicated by Radiologist)

May proceed with the following procedures as needed for diagnosis:

- Follow my Standing Orders on file with Breast Care Coordinator.
- I prefer the patient to see me prior to any invasive procedure.
- Please have patient consult with surgery prior to biopsy.
- Surgical evaluation for palpable abnormality.

Preferred Surgeon: Dr. _____

MRI **Breast Ultrasound**

Image Guided Needle Biopsy **Dexa Scan/Bone Density**

Right Left Bilateral

Referring Physician's Printed Name & Signature:

Name (*Please Print*): _____ Signature: _____

Office Address: _____ Phone: _____

Date / Time: _____