alinea
MEDICAL IMAGING

a Rezolut partner

BREAST HEALTH

REFERRING PHYSICIAN'S OFFICE

NAME:
ADDRESS:
TEL:
FAX:

Date: _____

Patient Name: _____

Date of Birth: _____ Exam Date: _____ Time: _____

PATIENT INSTRUCTIONS:

- Do not use powder, deodorant, or perfume on day of exam. Please wear a two-piece outfit for your convenience.
- Please bring previous mammograms if performed at another institution.

INSTRUCCIONES PARA EL PACIENTE:

- No use talco, desodorante o perfume en el día del examen. Por favor, use un traje de dos piezas para su conveniencia.
- Por favor traer mamografías anteriores que hayan sido realizadas en otra institución.

PHYSICIAN REFERRAL

☐ **SCREENING MAMMOGRAM**

- Asymptomatic women
- General pain or non focal complaints
- History of breast cancer with mastectomy/ screening of contralateral breast

☐ **DIAGNOSTIC VIEWS or US**
to be scheduled if needed

BREAST ULTRASOUND

☐ BILAT ☐ R ☐ L

Please check all that apply:

- ☐ Palpable abnormality
- ☐ Evaluation of nipple discharge
- ☐ Follow up ultrasound detected lesion
- ☐ Evaluation of known breast cancer
- ☐ Evaluate silicone implant for rupture

BREAST BIOPSY

Stereotactic ☐ R ☐ L
US Guided ☐ R ☐ L

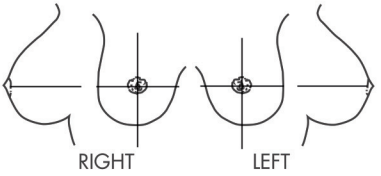
DIAGNOSTIC MAMMOGRAM
Include Breast Ultrasound if needed.

☐ BILAT ☐ R ☐ L

Please check all that apply:

- ☐ Call back for incomplete screening exam
- ☐ Focal palpable mass / focal pain
- ☐ Focal skin changes
- ☐ Bloody nipple discharge
- ☐ History of breast cancer within last 5 years
- ☐ Other _____

Please indicate area of concern



Clinical indication/diagnosis: _____

Physician's Full Name: _____

Physician's Signature: _____

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www.alineamed.com