alinea
MEDICAL IMAGING

BREAST HEALTH

REFERRING PHYSICIAN'S OFFICE

NAME:
ADDRESS:
TEL:
FAX:

TOLL-FREE: (844) 674-1295

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

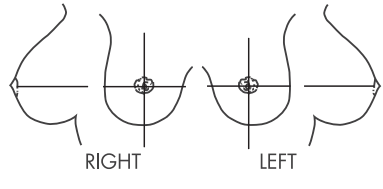
DIAGNOSTIC MAMMOGRAM
Include Breast Ultrasound if needed.

☐ 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: _____

2700 N. Main Street, #1107 Santa Ana, CA 92705 **P** (714) 380-6740 | **F** (909) 622-8046
1818 N. Orange Grove Ave, #101 Pomona, CA 91767 **P** (909) 622-3166 | **F** (909) 622-8046

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PATIENT REGISTRATION FORM

CONTACT: (909) 622-3166

LAST NAME	FIRST	MI

STREET	APT#	CITY	STATE	ZIP CODE

DATE OF BIRTH (MM/DD/YY)	AGE	SEX	SOCIAL SECURITY#	EMAIL

CELL PHONE	ALTERNATE PHONE	PATIENT STATUS
		☐ NEW ☐ RETURNING

METHOD OF PAYMENT ☐ **PPO** ☐ **HMO-IPA** ☐ **MEDICARE** ☐ **MEDI-CAL** ☐ **EWC** ☐ **SELF-PAY** ☐ **BILL DOCTOR / CLINIC**

INSURANCE CARRIER / MEDICAL GROUP	MEMBER ID#	GROUP#

IF PATIENT IS UNDER 18, ACCOMPANYING PARENT NAME

REFERRING PROVIDER / CLINIC

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I consent to and authorize the administration of all diagnostic and therapeutic treatments by Alinea Medical Imaging radiologists that may be considered advisable or necessary in the judgement of the attending radiologist. I authorize Alinea to furnish my insurance carrier(s) information regarding my history, physical findings and treatment rendered.

X DATE

AUTHORIZATION TO PAY BENEFITS AND ACCEPTANCE OF PAYMENT RESPONSIBILITY

I authorize payment of benefits directly to the provider for the services rendered. In addition, in the event that my insurance carrier(s) refuse payment for services rendered, I agree that I will be held financially responsible for payment.

X DATE

PRIOR FILM AND REPORT RELEASE

I hereby authorize the release of my films and reports in addition to any Surgical Pathology reports pertaining to my past medical history to: Alinea Medical Imaging facilities.

I hereby authorize Alinea Medical Imaging to release my films and reports to any requesting physician or medical facility providing my medical care for continuing treatment in my health care. This authorization will remain in effect for 1 year from the date of my signature.

X DATE

OFFICIAL USE

MRN: _____ DOS: ___/___/___ Acc#: _____ Tech: _____ TA: _____

Staff Comments: *(does not appear on report)*

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BREAST IMAGING PATIENT FORM

CONTACT: (877) 426-3926

Last: _____ First: _____ MI: _____

Age: _____ Date of Birth: _____ Today's Date: _____

OFFICIAL USE
MRN:

When was your last mammogram? **MONTH/YEAR** _____ **Where?** _____

Are you currently pregnant or breastfeeding? ☐ **NO** ☐ **YES** **Date of your last menstrual period:** _____

1. BREAST HEALTH: Are you currently having any problems with your breasts? ☐ **NO** ☐ **YES**
If yes, please fill out the following:

Lump	☐ Right	☐ Left	☐ Both	How Long? _____
Pain or Tenderness	☐ Right	☐ Left	☐ Both	How Long? _____
Infection or Inflammation	☐ Right	☐ Left	☐ Both	How Long? _____
Recent Breast Injury	☐ Right	☐ Left	☐ Both	How Long? _____
Nipple Abnormality	☐ Right	☐ Left	☐ Both	How Long? _____
Nipple Discharge	☐ Right	☐ Left	☐ Both	How Long? _____

Please describe:

2. BREAST CANCER HISTORY: Have you ever been diagnosed with breast cancer? ☐ **NO** ☐ **YES**
If yes, please fill out the following:

Which Breast? ☐ None ☐ Right ☐ Left ☐ Both Were you diagnosed in the last two years? _____ What age? _____

Which treatments did you receive? ☐ Lumpectomy ☐ Mastectomy ☐ Breast Reconstruction ☐ Radiation Therapy ☐ Chemotherapy ☐ Prescribed Tamoxifen or Evista

Do you have a mutation in either the BRCA1 or BRCA2 gene? ☐ Never Tested ☐ Tested Normal ☐ BRCA1+ ☐ BRCA2+

3. PERSONAL CANCER HISTORY: Have you ever been diagnosed with other cancers? ☐ **NO** ☐ **YES**
If yes, please fill out the following:

Cancer Type/Location: _____ *What age?* _____

4. IMPLANTS: Do you have implants? ☐ **NO** ☐ **YES**
If yes, please fill out the following:

Implant Type? ☐ Unknown ☐ Saline ☐ Silicone

5. PROCEDURES: Have you had any breast procedures... Biopsy, Reduction, MRI, etc.? ☐ **NO** ☐ **YES**
If yes, please fill out the following:

Breast Reduction/lift	☐ Right	☐ Left	☐ Both
Breast Biopsy	☐ Right	☐ Left	☐ Both

Other: _____

Please describe procedure including biopsy results:

6. FAMILY HISTORY: Have family members been diagnosed with breast or ovarian cancer? ☐ **NO** ☐ **YES**
If yes, please mark the relationship as well as the age of diagnosis:

☐ Mother	☐ Sister	☐ Maternal Grandmother	☐ Paternal Grandmother	☐ Maternal Aunt	☐ Paternal Aunt
Age:_____	Age:_____	Age:_____	Age:_____	Age:_____	Age:_____

7. ACCEPTANCE:

I have been instructed regarding the importance of annual screening mammography after the age of 40.

Patient Signature: _____ Date: _____

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INFORMED CONSENT AGREEMENT:
WAIVER, ASSUMPTION OF RISK, & RELEASE

Name of Patient: _____

I acknowledge that Alinea Medical Imaging, PC informed me that they are compliant with the Centers for Disease Control & Prevention guidelines to help prevent the spread of COVID-19. These include use of Personal Protective Equipment, Increased Facility Disinfection, Patient and Employee Screening and Social Distancing where possible.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk and accept sole responsibility that I may be exposed to or infected by COVID-19 by visiting the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death. Being aware of these risks and the fact that there are other unknown potential risks and/or complication, it is still my desire to visit the Center.

Check below which applies to you:

☐ By signing below, I affirm that **I have not been diagnosed with COVID-19. I have not been** cleared as noncontagious by a physician, state or local public health authorities. I further affirm that **I do not believe that I have been exposed** to a person with a confirmed or suspected case of COVID-19. **I am not experiencing any new primary symptoms of illness related to COVID-19 such as a fever, cough, shortness of breath; or a combination of any additional symptoms including chills, muscle pain, headache, sore throat and/or loss of taste or smell.** I am following recommended guidelines to the greatest extent possible, e.g., practicing social distancing by participating in group activities of fewer than ten, trying to maintain separation of six feet from others, and otherwise limiting my exposure to the coronavirus.

☐ By signing below, I affirm that **I have been diagnosed with COVID-19. I have been cleared as noncontagious** by a physician, state or local public health authorities. **I have been symptom free** without fever reducing medication for at least 72 hours prior to my scheduled appointment. **I have provided to the Center verbal or written confirmation** from my referring physician that I am outside of my quarantine period. **I do not believe that I have been further exposed** to a person with a confirmed or suspected case of COVID-19. **I am not experiencing any new primary symptoms of illness related to COVID-19 such as a fever, cough, shortness of breath; or a combination of any additional symptoms including chills, muscle pain, headache, sore throat and/or loss of taste or smell.** I am following recommended guidelines to the greatest extent possible, e.g., practicing social distancing by participating in group activities of fewer than ten, trying to maintain separation of six feet from others, and otherwise limiting my exposure to the coronavirus.

☐ By signing below, I affirm that if I have been exposed to a person with a confirmed or suspected case of COVID-19, I have worn appropriate Personal Protective Equipment.

Signature: _____ Date _____

Patient (or Patient Responsible Party if applicable)

Staff Signature: _____ Print Staff Name: _____ Date _____

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SELF REFERRAL CONSENT

CONTACT: (909) 622-3166

Name / *Nombre* _____

Date of Birth / *Fecha de Nacimiento* _____

You are here for a mammogram without a Doctor's Order. Alinea Medical Imaging agrees to perform the mammogram. We will send you the clinical exam report for future reference and a lay letter (the report in easy to understand terms). We usually mail out reports with-in 5 working days of the exam. If you have positive results and need further imaging or care, we will provide you with a current list of MD's, clinics, and organizations that may be able to help you get the recommended follow-up care with little or no cost to you.

Alinea Medical Imaging will be under no circumstance legally bound to ensure that you are seen / or that you are given follow-up care. You, as the patient will assume all responsibility for any / all follow-up care or treatment should any be necessary.

SIGNING BELOW INDICATES THAT I HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND AGREE TO PROCEED WITH THE MAMMOGRAM EXAMINATION.

Usted esta aqui para una mamografia sin una orden de un doctor. Alinea Medical Imaging se compromete a realizar la mamografía. Nosotros le mandaremos el informe clinico para su referencia en un futuro y una carta con un reporte facil de entender. Usualmente mandamos los reportes 5 dias de la fecha del examen. Si tiene resultados positivos y necesita mas imagenes o cuidado, le daremos una lista de doctores, clinicas, y organizaciones que podran ayudarla a obtener el cuidado recomendado con poco o ningun costo para usted.

Alinea Medical Imaging no sera en ningun caso legalmente obligado en asegurarse que usted sea vista o que se le de seguimiento. Usted como paciente asume toda responsabilidad de cualquier seguimiento o cuidado si es necesario.

MI FIRMA, QUE APARECE A CONTINUACION, INDICA QUE HE LEIDO ENTENDIDO LA INFORMACION ANTERIOR Y QUE DOY MI CONSENTIMIENTO PARA PROCEDER CON LA MAMOGRAFIA.

X: _____ **Date** / *Fecha* _____

PATIENT SIGNATURE / FIRMA DEL PACIENTE

_____ Date: _____

ALINEA REPRESENTATIVE

Do you currently have a doctor that you would like your results sent to?
¿Tiene actualmente un médico que le gustaría que sus resultados sean enviados a?

☐ YES / SÍ ☐ NO

If yes, please provide the doctor's information below / En caso afirmativo, proporcione información del médico a continuación:

Doctor's name / *Nombre del doctor* _____

Address / *Dirección* _____

_____

Telephone _____

Fax _____

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IMPLANT PATIENT CONSENT FOR MAMMOGRAPHY

Since you have implants we need to advise you of the following:

- The implant obscures some of the tissue so two sets of images will be taken when possible to visualize as much tissue as possible. One set of images will have the implant in the picture and another will be taken with the implant moved out of the picture.

- Implant ruptures are rare but have occurred. Like a balloon, an implant that is old or weakened can rupture at any time. This is an extremely rare occurrence but cannot be ruled out, as the condition of the implant cannot always be verified by feel prior to the mammogram.

In the first set of pictures, slight compression will be applied to your entire implant to hold it in place and prevent motion. These films are often helpful in visualizing a rupture that occurred previously. If a rupture is seen on the images the radiologist will note this in the report to your physician. Your doctor may then order an MRI as this is a more sensitive tool to look for or to view the extent of a rupture.

A second set of pictures will be taken if your implant is movable by pushing your implant back to look at the tissue in front of the implant. Normal compression must be applied and similar to a mammogram of a breast without an implant this compression may cause some slight discomfort but lasts only a few seconds. It is sometimes unavoidable to catch a tiny bit of the implant under the compression and if there is a weakness in the capsule this might cause it to leak. The same could happen if you hit that spot with any object.

Since occurrence of a rupture during mammography is rare and the benefit of mammography in early detection has been proven, we hope that you will proceed to allow us to perform your implant mammogram. Mammography is the earliest form of detection for changes in the breast but mammography is not perfect and does not detect all changes.

Puesto que usted tiene implantes tenemos que informarle de lo siguiente:

- El implante oscurece parte del tejido por lo que se tomarán dos conjuntos de imágenes siempre que sea posible para visualizar la mayor cantidad de tejido posible. Un conjunto de imágenes tendrá el implante en la imagen y otra se toma con el implante fuera de la foto.

- Roturas de implantes son raros, pero han ocurrido. Como un globo, un implante que es de edad o debilitado puede romperse en cualquier momento. Este es un acontecimiento extremadamente raro, pero no se puede descartar, como la condición de que el implante no puede siempre ser verificada por el tacto antes de la mamografía.

En el primer conjunto de imágenes, ligera compresión se aplicará a la totalidad de su implante para mantenerlo en su lugar y evitar el movimiento. Estas imagenes suelen ser útiles en la visualización de una ruptura que se produjo con anterioridad. Si la ruptura se ve en las imágenes el radiólogo tomará nota de ello en el informe a su médico. Luego, su médico puede ordenar una resonancia magnética, ya que es una herramienta más sensible para buscar o para ver el alcance de una ruptura.

Se tomará una segunda serie de imágenes si el implante se puede mover empujando su implante hacia atrás para mirar el tejido delante del implante. Compresión normal debe ser aplicada y similar a una mamografía de un seno sin un implante esta compresión puede causar una ligera molestia, pero dura sólo unos pocos segundos. A veces es inevitable para coger un poco de el implante bajo la compresión y si hay una debilidad en la cápsula que esto podría provocar que se generen fugas. Lo mismo podría suceder si usted golpea ese lugar con cualquier objeto.

La aparición de una ruptura durante la mamografía es poco común y el beneficio de la mamografía en la detección temprana se ha demostrado, esperamos que procederá a permitirnos realizar la mamografía implante. La mamografía es la forma más reciente de la detección de cambios en la mama, pero la mamografía no es perfecta y no detecta todos los cambios.

X: _____ **Date** / *Fecha* _____

PATIENT SIGNATURE / FIRMA DEL PACIENTE

_____ Date: _____

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PATIENT CONSENT FOR MAMMOGRAPHY UNDER 40

Breast Cancer Screening in younger women:

I understand that the American College of Radiology recommends starting routine screening mammograms at the age of 40. In certain cases of increased risk, including family history and genetic predisposition, it may be appropriate to start screening earlier. A baseline mammogram between the age of 35-40 can be performed and is often covered by insurance. In the case of family history of breast cancer in a first degree relative (Mother or Sister), it is advised to begin annual screening mammograms 10 years prior to the age of diagnosis in the relative.

Generally, screening mammograms in women under 35 with average risk is not recommended due to the lower incidence of breast cancer in this age group, the decreased sensitivity of mammography due to increased breast density, and increased risk of radiation exposure. The average amount of radiation exposure from a standard digital mammogram is equivalent to the average amount of radiation received from the background environment in about 7 weeks. However, there is a slight increased risk of developing a cancer in the future with any increased radiation exposure and the risks are greater in younger women. By signing this consent, I agree to undergo screening mammography despite the associated risks and lower incidence of cancer.

However, by choosing to undergo this examination, I understand that my insurance may not cover this procedure if I have not yet reached the recommended age of 40 or I have not met my plan requirements. I understand and acknowledge it is my responsibility to understand my insurance benefits pertaining to breast imaging procedures. I agree to pay in full at the time of service for the procedure in the setting where my insurance will not cover the procedure due to my age.

X: _____ **Date** _____

PATIENT SIGNATURE

_____ Date: _____

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