

One Convenient Number!

Call to schedule your appointment

804.237.6666

**Monday – Friday
8 a.m. – 5 p.m.**

Date: _____

Time: _____

Please arrive 30 minutes prior to your appointment time and bring the following information with you:

- This form signed by your referring physician
- Insurance card
- Photo ID (i.e. license, passport)
- Any previous breast images and reports performed at a non-VCU Health facility to include mammograms, breast ultrasounds, breast biopsies, and breast MRIs, if available

Facility Preference:

- ☐ **Stony Point Breast Imaging**
9000 Stony Point Pkwy, 2nd Floor
- ☐ **Adult Outpatient Pavilion (AOP)**
1001 East Leigh Street, 6th Floor

When faxing this form, please include a copy of patient's insurance card.

Fax: 804.237.6616

☐ Check here if you'd like the images sent via Life Image

Patient Name: _____ Today's Date: _____

Patient Phone #: _____ Date of Birth: _____

Clinical History: _____

Referring Physician: _____ Physician Signature: _____

NPI #: _____ Physician Phone #: _____

IMAGING REQUEST

SCREENING MAMMOGRAM (Z12.31)

- ☐ No current breast concerns
- ☐ Personal history of surgery for breast cancer > 1 year ago
- ☐ Family history of breast cancer (Z80.3) (specify): _____

IMPORTANT: Please select statement to proceed with additional imaging, as needed

☐ "I agree to diagnostic mammography, breast-axilla ultrasound, aspiration/biopsy, pathology, ductography and/or breast MRI as deemed medically indicated by the radiologist."

Check to approve Point of Care Testing necessary to proceed with imaging:

- ☐ Radiology Creatinine (POCT)
- ☐ Radiology Pregnancy Test (POCT)

DIAGNOSTIC MAMMOGRAM ☐ Right ☐ Left ☐ Bilateral

Mark the indications for diagnostic study:

- ☐ Palpable lump(s) (N63) Indicate location(s) on diagram
- ☐ Palpable breast thickening / induration of breast (N64.51) Indicate location(s) on diagram
- ☐ Nipple discharge (N64.52) ☐ Right ☐ Left
- ☐ Retraction of nipple (N64.53) ☐ Right ☐ Left
- ☐ Breast pain (focal) (N64.4) Indicate location(s) on diagram
- ☐ Personal history of breast cancer (Z85.3) Date of diagnosis: _____
- ☐ Follow-up of previous mammographic or sonographic abnormality (R92.8)
OR known breast cancer: (enter ICD-10 code for specific breast cancer): _____
- ☐ Pre-surgical or post-neoadjuvant treatment
- ☐ Other signs & symptoms in breast (Z64.59) (please specify): _____

DIAGNOSTIC BREAST AND AXILLA ULTRASOUND ☐ Right ☐ Left ☐ Bilateral

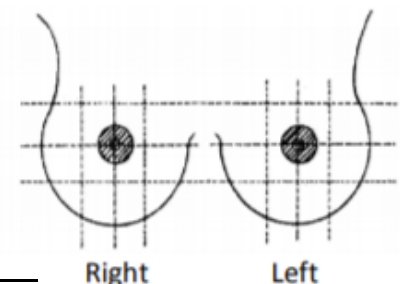
BREAST MRI INDICATION: _____

PROCEDURE ☐ Cyst aspiration ☐ Core needle biopsy ☐ Ductogram (galactogram)
☐ Right ☐ Left ☐ Bilateral

EXAM AND PERTINENT INFORMATION

Date of Last Breast Exam: _____

☐ Normal ☐ Abnormal



Medical Records Copy
HM-R 1545 (rev.05-21)



DT-ORDER