# BREAST IMAGING REFERRAL FORM

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Fayetteville, NC 28304
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THE BREAST CENTER of VALLEY REGIONAL IMAGING

Scheduling: (910) 221-2500
Scheduling Fax: (910) 221-2468

**STAT REFERRAL: Yes / No**

**Fax Referrals: (910) 221-2468**

## Patient & Referring Physician Information

Patient Name: _____ DOB: _____ Patient Phone: _____ Alt:_____

ICD 10 / Diagnosis / Indication: _____ CDS / Authorization #_____

Special Instructions / Notes: _____

Referral Coordinator: _____ Phone:_____ Fax:_____

Referring Physician (Print) _____ Physician Phone: _____ Stat Phone:_____

**Provider Signature:** _____ **Order Date:** _____ **Provider CC:**_____

## Screening Breast Imaging (Routine screening exam; patient has no breast problems)

**Screening Mammogram**

☐ w/Implants ☐ No Implants

**Provide Previous Imaging Reports/Information Conducted at Another Facility:**

_____

## ** COMPREHENSIVE BREAST IMAGING REFERRAL **

☐ **Screening and/or Diagnostic Breast Imaging at Radiologist's Discretion:**

Checking box authorizes Radiologist to schedule a Screening Mammogram, Diagnostic Mammogram, Ultrasound, and/or Biopsy if indicated to streamline patient care. If appropriate, please mark clinical indications below.

## Diagnostic Breast Imaging

☐ **Diagnostic Mammography Work-up** (Ultrasound at Radiologist's discretion)
- ☐ Implants
- ☐ Right ☐ Left ☐ Bilateral

*** If patient has not had a BL MG in previous 10 months a BL is required***

☐ **Breast Ultrasound** (Mammogram at Radiologist's discretion)
- ☐ Right ☐ Left ☐ Bilateral

☐ **Magseed**
- ☐ Breast ☐ Right ☐ Left ☐ Bilateral
- ☐ Axilla ☐ Right ☐ Left ☐ Bilateral
- *Indicate location* _____
- ☐ Single ☐ Bracket ☐ Multi

**Lesion Type**
- ☐ Mass ☐ Clip ☐ Calcs ☐ Other_____

☐ **Needle Wire Localization**
- ☐ Breast ☐ Right ☐ Left ☐ Bilateral
- ☐ Axilla ☐ Right ☐ Left ☐ Bilateral
- *Indicate location* _____
- ☐ Single ☐ Bracket ☐ Multi

**Lesion Type**
- ☐ Mass ☐ Clip ☐ Calcs ☐ Other_____

***Provide Previous Imaging Reports/Information Conducted At Another Facility***

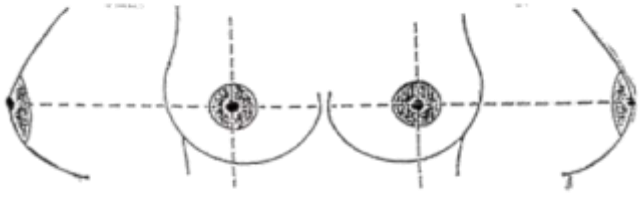
_____

## Clinical Indications for Comprehensive or Diagnostic Breast Imaging

**Select all that apply:**
- ☐ Mass/Lump
- ☐ Thickening
- ☐ Nipple discharge/inversion/skin changes
- ☐ Focal pain/tenderness, unrelated to menses
- ☐ Dimpling, contour deformity
- ☐ Previous breast cancer (new symptoms)
- ☐ Abnormal Screening Mammogram
- ☐ Follow-Up Previous Findings:_____
- ☐ Other Specify:_____

**Please Mark Area(s) of Concern:**

☐ Right ☐ Left ☐ Bilateral



RIGHT LEFT

**MARK CLINICAL FINDINGS ON DIAGRAM**

***Provide Previous Imaging And Reports Information If Prior Imaging Was Conducted At Another Facility****