RADIOLOGY REFERRAL FORM - BREAST IMAGING & BONE DENSITY

Date of Referral: _____ Referring Provider: _____

Patient Name (first, MI, last): _____ D.O.B. _____

Patient Phone: (_____) _____(home) (_____) _____(work or cell)

❍ Interpreter needed: _____ *(language)* ❍ Physical Assistance Required

Written Diagnosis/Reason/Symptom for Exam(s) REQUIRED

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. **Rule out, Possible or Probable Conditions cannot be coded.** For Medicare Policy information see the Part B Bulletin or www.noridian.com/medweb

Notes: Height _____ Weight _____ Breast Cancer History lt rt

Mastectomy History lt rt

Allergies: _____ Implants? ❍ Yes ❍ No

Prior Exams:

Date of Service Facility Location

_____ _____

Other Last Name: _____

Screening Services

Mammography

Date of last Mammogram: _____

❑ Mammogram *(asymptomatic)* lt rt bilat

Bone Densitometry (DEXA)

❑ Spine & Femur

❑ Other (specify) _____

Diagnostic Services

❑ Mammogram *(symptomatic)* lt rt bilat
(Ultrasound if needed)
❍ Needle Biopsy if indicated

❑ Needle Loc/Placement lt rt bilat

❑ Stereotactic Breast Biopsy lt rt bilat

❑ Galactogram lt rt bilat

Ultrasound

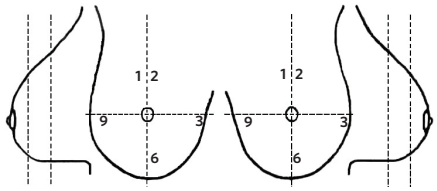
❑ Breast *(limited)* lt rt bilat

❑ Breast *(complete)* lt rt bilat

❑ Breast Cyst Aspiration lt rt bilat

❑ Guided Breast Biopsy lt rt bilat

Indicate area of concern



Document Palp Abn: _____

O'clock: ___ N+ _____

❍ **Radiologist may change order** ❍ Yes ❍ No

❍ **Can perform additional imaging as needed per protocol** ❍ Yes ❍ No
(i.e. add views, follow up ultrasound, etc.)

MRI

Patient has a Pacemaker or Implanted Device. ❍ Yes ❍ No

Creatinine/GFR _____ /_____ Date Drawn: ____ / _____/ _____

❍ Creatinine blood draw at radiologist's discretion

❑ Breast MRI bilat with contrast

❍ Limited Chest MRI if indicated *(radiologist's discretion)*

❑ Breast MRI Guided Breast Biopsy lt rt bilat

Appointment:

Exam _____

M T W Th F Sat Sun

Date: ____-_____-_____

Check In Time: ___:_____

Appt. Time: _____:_____

❑ Call patient to schedule

❑ Patient will call to schedule

Report

❑ Call STAT (_____) _____

❑ Fax STAT (_____)_____

❑ Fax Routine(____)_____

❑ Additional Report To:_____

_____

Images:

❑ CD ROM ❑ Deliver to my office

❑ Web PACS ❑ Send with patient

❑ CMC PACS ❑ Providence PACS

PCP: _____

Insurance

Send copy of patient's insurance card when faxing this referral.

Insurance(s) _____

_____

Authorization # _____

(if necessary)

Referring Provider Signature ⟶
Required for exam

_____

12.2017

EXAM LOCATION GRID

Preparing for your Mammogram:

- Please wear a two-piece outfit
- Do not wear powder, deodorant or lotion to exam

Bonney Lake

❑ Diagnostic Imaging Northwest - Bonney Lake
21110 SR 410 E, Suite 110, Bonney Lake, WA 98391
Phone: (253) 841-4353; Fax: (253) 446-3973

Lakewood

❑ TRA Medical Imaging - Lakewood
5919 100th Street SW, Lakewood, WA 98499
Phone: (253) 761-4200; Toll Free: (866) 761-4200
Fax: (253) 761-4201

Olympia

❑ TRA Medical Imaging - on Lilly
500 Lilly Rd NE, Suite 160, Olympia, WA 98506
Phone: (360) 413-8383; Toll Free: (866) 761-4200
Fax: (360) 413-8323

Puyallup

❑ Diagnostic Imaging Northwest - Puyallup
222 15th Avenue SE, Puyallup, WA 98372
Phone: (253) 841-4353; Fax: (253) 446-3973

❑ Diagnostic Imaging Northwest - Sunrise
11212 Sunrise Blvd. E, Suite 200, Puyallup, WA 98372
Phone: (253) 841-4353; Fax: (253) 446-3973

Tacoma

❑ Carol Milgard Breast Center
4525 South 19th Street, Tacoma, WA 98405
Phone: (253) 759-2622; Toll Free: (866) 758-2622
Fax: (253) 572-4324

Bone Densitometry	Mammogram - Screening	Mammogram - Diagnostic	Breast Ultrasound	Needle Localization	Breast Biopsy	Galactogram	Breast MRI	Breast Cyst Aspiration
●	●	●	●					
●	●							
●	●	●	●	●	●	●	●	●
●	●	●	●	●	●	●	●	●
●	●	●	●					
●	●	●	●	●	●		●	●