York Hospital

BREAST CARE

BREAST CARE DIAGNOSTIC IMAGING ORDER

Patient Name: _____

DOB: _____

Patient's Phone Number: _____

Today's Date: _____

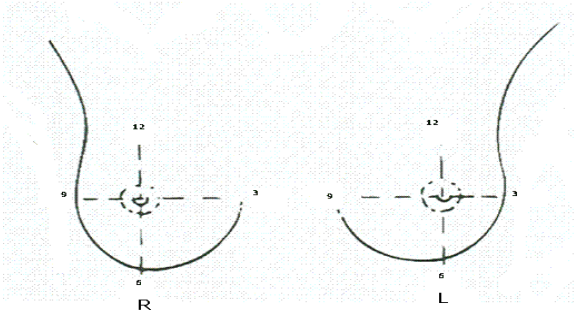
Fax #: (207) 351-2036

☑ Mammogram as indicated per ACR appropriateness criteria

☑ Ultrasound as indicated per ACR appropriateness criteria

Reason for diagnostic appointment:

Symptoms:	☐ Breast	☐ Axilla
☐ Lump	☐ Right	_____ o'clock
	☐ Left	_____ o'clock
☐ Focal Pain	☐ Right	_____ o'clock
	☐ Left	_____ o'clock
☐ Discharge	☐ Right	_____ o'clock
	☐ Left	_____ o'clock



☐ History of breast cancer

☐ Other: _____

* Clinically significant breast pain is focal and noncyclical.
** Pathologic nipple discharge is (any of the following): unilateral, from a single duct or orifice, spontaneous, serous or bloodstained.

To comply with Federal Regulations, we require written requisition for consultation / evaluation of all diagnostic patients. If anything other than a screening mammogram is requested, we must have written requisition.

REFERRING PHYSICIAN PRINTED NAME: _____

REFERRING PHYSICIAN SIGNATURE: _____ DATE: _____