BREAST CARE
A unique service of York Hospital
Diagnostics — Answers — Guidance

Patient Name: _____

DOB: _____

Today's Date: _____

BREAST CARE DIAGNOSTIC ORDER

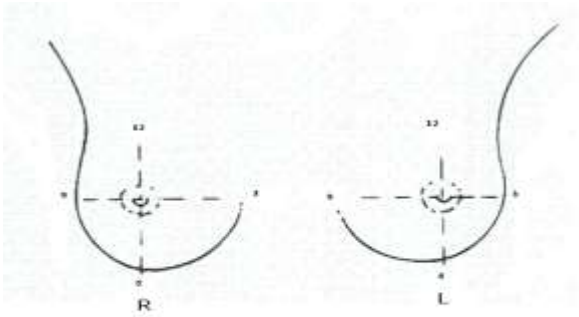
Diagnostic Appointment _____

Mammogram	R	L	Bilateral
Ultrasound	R	L	Bilateral

Reason for diagnostic appointment:

Symptoms:

☐ Lump	☐ Right	_____ o'clock
	☐ Left	_____ o'clock
☐ Focal Pain	☐ Right	_____ o'clock
	☐ Left	_____ o'clock
☐ Discharge	☐ Right	_____ o'clock
	☐ Left	_____ o'clock
	☐ Self Expressed	
	☐ Spontaneous	



☐ History of breast cancer

☐ Other: _____

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: _____

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