REQUEST FOR MAMMOGRAPHY SERVICES

'OHANA

Breast Imaging Center of Excellence

yakimamemorial.org

MEMORIAL | Comprehensive Cancer Care

Ordering care provider _____

Patient's name_____ DOB _____

*Best daytime phone number to contact patient _____ Alternate_____

Date last clinical breast exam was performed _____

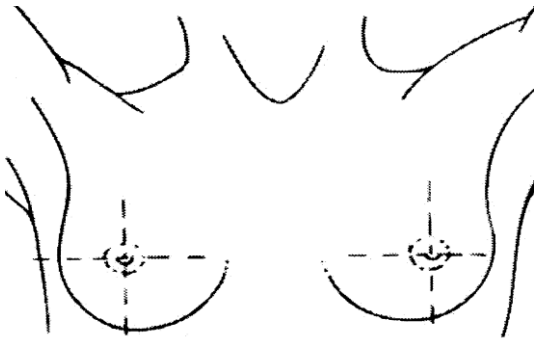
Mammogram requested

☐ **Screening mammogram** w/add'l Images and/or Breast Ultrasound, as needed, for abnormal screening Mammogram as recommended by Radiologist

☐ **Screening mammogram** ***(Asymptomatic only)***
Breast Implants ___ No ___ Yes

☐ **Diagnostic mammogram /** ☐ **Breast Ultrasound**
Breast Implants ___ No ___ Yes

☐ ***Lump*** ☐ **Pain** ☐ **Skin Changes** ☐ **Nipple discharge**
(use diagram to mark location)



Right Breast Left Breast

____ Right ____ Left ____ Bilateral

*Clock position: _____
*Distance from nipple (cm): _____
*Lesion size (mm): _____
*Lesion description: _____

Chart are needed for diagnostic imaging

ICD 10 Code _____ required

Other, describe: _____

X_____ _____
Required Provider's Signature ***Date & Time***
(required)

Breast history (mark circles that apply)

○ Mastectomy **[Right / Left]** ○ Lumpectomy **[Right / Left]** ○ Benign Biopsy ○ Family members with breast cancer

Is a language interpreter needed for this patient? _____

Does this patient have special needs (i.e. hearing or vision impaired, wheelchair use)? _____

Patient needs to request breast images from previous facility **prior to appointment**, if last mammogram was not with 'Ohana.

PLEASE ADVISE YOUR PATIENT OF THE FOLLOWING:

. Refrain from wearing deodorant, lotions and/or powders to appointment

. Small children **must be** attended by an adult while patient is receiving diagnostic services

. Please bring photo ID and insurance cards for check-in process

Please fax this form to 'Ohana at (509) 249-5319

Appointment scheduled on _____Date _____ Time_____