



Breast Imaging Center - Referral and Procedure Data Form

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PLEASE FAX THE FOLLOWING INFORMATION:

- ☐ Need all breast imaging – Current W/REPORTS and 2 years prior if applicable
- ☐ Order/referral for biopsy procedure
- ☐ Patient demographics and insurance information

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

Ordering Provider: _____ Phone: _____ Fax: _____

***Ordering provider to notify patient of pathology. Office contact: _____

Referral for: ☐ Upright Stereotactic needle core BX 2D/3D tomosynthesis ☐ Ultrasound guided needle core biopsy

Diagnosis code: _____

Indications: _____ ☐ Right ☐ Left ☐ Bilateral

Provider Signature: _____ Date: _____ Time: _____

Previous Mammo/ US/MRI: ☐ Methodist ☐ Sending When/Where: _____

Is the patient currently taking any ASA or Blood thinners? ☐ No ☐ Yes If yes, what: _____

Any contraindications of physical limitations, allergies? _____

****Radiologist review will be necessary for outside imaging cases. MJE Breast Imaging will contact biopsy candidates in 1-3 business days to arrange biopsy time. Images should be forwarded to NE Methodist PACS via Powershare. *Physician to receive pathology 5-7 day post biopsy. And addendum by Radiologist with follow up recommendations.**

MJE MRN: _____ First patient contact (per MJE): _____ Initials: _____

Imaging Review -----

Radiologist: _____

Date: _____

Referring Provider notified: _____

Scheduling notified: _____

Patient notified: _____

Radiologists comments: _____

Ultrasound / Stereo / MRI Biopsy

Date: _____ Time: _____

MJE Imaging Notes: _____

Provider to notify pt of path: _____

Where pt follow if positive result: _____

Where pt follows if benign result: _____

******MJE Breast Health Center Referrals******

To refer a patient to MJE Breast Health Center surgeon or genetics/High Cancer Risk Clinic, please fax referral to fax 712-396-7944, call the receptionist at 712-396-4117, or call the BHC Nurse Navigator at 712-396-6326.

Confidentiality Notice: The documents accompanying this transmission may contain confidential or legally privileged information. If you are not the intended recipient, any disclosure or distribution is strictly prohibited. If you are not the intended recipient, please notify the sender immediately and destroy these documents.

Patient Label	
NAME: _____	DOB: _____
FIN: _____	MRN: _____

PERMANENT PART OF MEDICAL RECORD