Document Type: Orders/Referral
Subject: Breast Imaging – Referral Form MJE

*DR0152*

METHODIST JENNIE EDMUNDSON

# Breast Imaging Center - Referral and Procedure Data Form

**Attn: Pam Wright, R.T. (R)(M)**
**Ph: 712-396-6224 Fax: 402-815-9786**

**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.**

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

**PERMANENT PART OF MEDICAL RECORD**