BOSTON BREAST DIAGNOSTIC CENTER

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Diagnostic Breast Radiologist

REQUEST FOR MAMMOGRAPHY/BREAST IMAGING

Patient Name:_____ DOB:_____

Referring Physician:_____

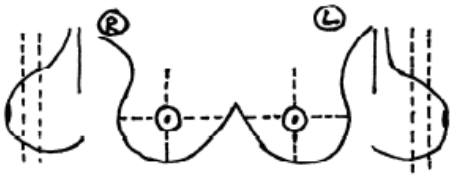
Phone #_____ Fax # _____

Screening Mammogram (Asymptomatic, Routine)
❒Mammogram

Diagnostic Evaluation
❒ Mammogram w/wo Contrast
❒ Breast Ultrasound
❒ Mammogram & Breast Ultrasound

Reason for Diagnostic Exam:	**Rt.**	**Lt.**
❒ Palpable Mass/Thickening	❒	❒
❒ Nipple Discharge	❒	❒
❒ Breast Pain (focal)	❒	❒
❒ Skin or nipple changes	❒	❒
❒ Personal Hx Breast Cancer	❒	❒
❒ Suspected infection/abscess	❒	❒
❒ Follow-up	❒	❒
❒Other Pertinent Findings:	❒	❒

Please indicate area of clinical concern on diagram.



_____

❒ **Biopsy if Indicated**

Physician signature:_____ Date:_____

To the Patient:
Your appointment is scheduled on: Date:_____ Time:_____

You are scheduled to be evaluated by a diagnostic Radiologist who specializes in breast disease. You will be having imaging studies which may include a mammogram, a clinical breast exam, an ultrasound and if necessary, a needle biopsy or cyst aspiration. The Radiologist will discuss the results with you and answer any questions you may have at that time. It is important for you to bring any prior mammogram films with you.

Please fax consult request to Boston Breast Diagnostic Center at 617-553-5353