

UWHC Radiology Outpatient Order Form Breast Imaging

Ordering Provider Name: _____	Patient Name: _____
Ordering Provider ID #: _____	MRN: _____
Ordering Provider Phone #: _____	DOB: ___/___/___ Appt Date: ___/___/___ Time: _____

Screening Mammography Does not require a health care provider order. Patients may schedule directly. Minimum 11 mo. interval required for Medicare. Routine, asymptomatic, annual, no new problems, Family Hx of Breast CA, Personal Hx of Breast CA not undergoing current treatment.

- Right Left **Diagnostic Mammography and possible Ultrasound as needed**
Symptomatic patient with new dominant mass, lumps, thickening or asymmetry, focal noncyclic pain, focal skin changes, possible inflammatory cancer, new onset spontaneous nipple discharge or nipple changes, Personal Hx of Breast CA undergoing current treatment. Additional imaging needed (BIRADS 0) or follow-up mammogram (BIRADS 3).
- Right Left **Diagnostic Breast Ultrasound and possible Diagnostic Mammography as needed**
Less than 30 years old with new dominant mass, lump or noncyclic pain; or at any age with recent normal mammogram but new clinical findings. Additional imaging needed (BIRADS 0) or follow-up ultrasound (BIRADS 3).
- Right Left **Galactogram / Ductogram** Surgical assessment recommended prior to scheduling.
New onset of single duct spontaneous serous or bloody nipple discharge
- Right Left **Breast MRI** May require insurance pre-authorization
Additional evaluation of clinical, mammography or ultrasound abnormality. High-risk surveillance. Silicone Implant evaluation. Staging and extent.
- Second Opinion on Non-UW Health Mammogram.** Clinical question to be answered, original mammogram images and radiology report required.

Prior Studies: Facility Name: _____ City/State _____ Date of exam ___/___/___
We suggest that the patient brings or forwards all prior studies to expedite interpretation. The final report may be delayed if prior studies from another facility are needed.

MINIMALLY INVASIVE IMAGE GUIDED PROCEDURES

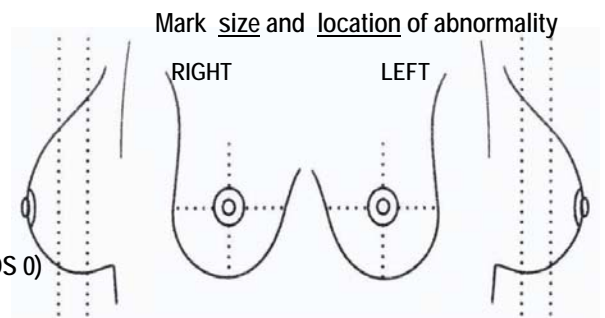
- Right Left Stereotactic guided Core Biopsy
- Right Left Ultrasound guided Cyst Aspiration
- Right Left Ultrasound guided Core Biopsy
- Right Left MR guided Core Biopsy

PRE-SURGICAL IMAGE GUIDED PROCEDURES

- Right Left Mammographic guided Needle Localization
- Right Left Ultrasound guided Needle Localization
- Right Left MR guided Needle Localization

Please mark current diagnosis or indication:

- New palpable dominant mass or lump
- New palpable breast thickening or asymmetry
- New focal noncyclic breast pain
- New spontaneous nipple discharge or nipple changes
- Additional evaluation of mammography, ultrasound or MR abnormality (BIRADS 0)
- Follow-up of mammography, ultrasound or MR abnormality. (BIRADS 3)



Reason for Exam: _____

Past Clinical / Surgical History: _____

Special Instructions: (sedation, wheelchair, nursing home, translator required, isolation precautions), _____

Ordering Provider Signature _____ Date: ___/___/___

Please fax the completed form to 608.262.7400 and call 608.266.6400 to schedule an appointment at
UW Hospital & Clinics Breast Center, West Clinic or East Clinic