OREGON IMAGING CENTERS

Breast Imaging Order Form

Today's Date: _____

General Scheduling: (541) 334-7555 ♦ TF: (888) 968-7608
Fax Orders: (541) 334-7564 (Do not fax STAT orders)

Due to patient privacy laws, we are unable to accept emailed forms. Please fax or print to ensure patient information is not subject to unauthorized access.

REPORTING INSTRUCTIONS
☐ Routine
☐ **STAT** Call Report - direct ph#_____
after hours ph# _____
☐ Pt to go ☐ Pt to wait
☐ **STAT** Fax Report -fx#_____

PATIENT LAST NAME **(REQUIRED)**	FIRST	M	DATE OF BIRTH **(REQUIRED)**	PATIENT DAYTIME PHONE
ORDERING CLINICIAN **(REQUIRED)** OFFICE LOCATION (if multiple)			CLINICIAN SIGNATURE **(REQUIRED – NO STAMPS)** DATE	
INSURANCE	PA#		SEND ADDITIONAL COPIES OF REPORT TO	
SYMPTOMS/DIAGNOSIS/HISTORY **(REQUIRED)** – INCLUDE ICD-9 CODE(S)				

☐ Radiologist may determine workup to include additional imaging or procedures through surgical referral if needed.

☐ Call my office prior to doing additional studies.

IMAGING & PROCEDURES

☐ SCREENING MAMMOGRAM (no breast symptoms)
OIC recommends diagnostic mammography for patients with personal history of breast cancer diagnosed within the last 4 years.

☐ SCREENING MAMMOGRAM WITH IMPLANTS (no breast symptoms)

☐ DIAGNOSTIC MAMMOGRAM (or additional views following screening)
☐ OK for US breast(s) if indicated

☐ ULTRASOUND BREAST(S) ☐ L ☐ R

☐ MRI BREASTS ☐ Lesion Detection ☐ Implant Integrity ☐ Pre-Op

☐ BREAST BIOPSY ☐ L ☐ R
☐ Stereo Core ☐ US Core ☐ MRI Core ☐ Other _____
☐ Sampling modality at radiologist discretion

☐ FNA (Fine needle aspiration/cyst/fluid collection) ☐ L ☐ R
☐ Ok to biopsy if unsuccessful aspiration attempt

Previous Breast Imaging: _____

PATIENT SYMPTOMS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NEEDLE LOCALIZATION

☐ RADIOLOGIST DISCRETION Right; position _____
☐ MAMMOGRAPHY GUIDED Left; position _____
☐ ULTRASOUND GUIDED
☐ MRI GUIDED

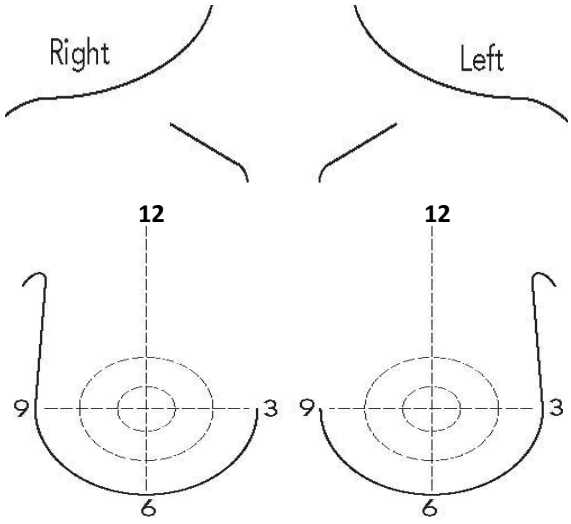
Diagnosis:_____

Special Instructions (ex: bracket or multiple sites)

_____

_____

SCHEDULED SURGERY DATE _____ TIME _____

Location: ☐ SHRB ☐ NSC Day Surgery

☐ (SLN) Sentinel Lymph Node