DEPARTMENT OF DIAGNOSTIC IMAGING
NEWPORT HOSPITAL

MAMMOGRAPHY REQUEST FORM

TO SCHEDULE CALL **- 1-866-4UR-XRAY** OR FAX-401-845-4292
(1-866-487-9729)

PATIENT INFORMATION:

Name: _________________________________ Date of Birth: ______________________________

MR#: ________________________ Phone # (Home)_______________ (Work) _______________

Healthcare Plan(s)______________________________ Number(s)___________________________

______________________________ ___________________________

If the patient's most recent mammogram was performed at a facility other then Newport Hospital, please inform the patient that every effort must be made by them to obtain those original films before this examination, or the report may be delayed while we await comparison.

Date of last Mammogram:________________________

MAMMOGRAPHY EXAM REQUESTED:

Screening Mammography (Asymptomatic)

Diagnostic Mammography

Bilateral Unilateral (which? Left Right)

Approval to order ultrasound if needed

REQUIRED **PATIENT'S HISTORY:**

Indications or Symptoms:

Palpable Mass: Location: ________________________Diagram:

Nipple Discharge Left Right
Skin Changes (Thickening, Retraction, Coloring, etc.)
Follow Up to Abnormal Screen
Personal History of Breast Cancer
Work Up for Metastatic Disease
Prior Augmentation Procedures
Other______________________

Ordering Information-

Date of Request: ____________________

Requesting Physician: ________________ Attending Physician: _______________________________

Requesting Physician's Phone or Pager #: ____

Name of Person Taking Request if ordered By Phone: ____

REQUIRED **Signature of Requesting Physician**: ____
Date:_____________

Form #875-1242