McLAREN OAKLAND

P.A.T. FOR BREAST SURGERY CONSULT-ASSESSMENT

Department of Radiology

Date: ____ / ____ / ___ Time: _____

Patient Name: _____ D.O.B: ____ / ____ / ____

Physician Requesting: _____ Fax: _____

Exam: _____

Reading:

_____

_____

_____

_____

_____

Radiologist: _____Date_____Time_____

PAT Technologist: _____Date_____Time_____

FOR DEPARTMENT USE ONLY

Please Circle one

Surgery Location: ASC Hospital

Needle Localization Location: MIC Hospital

Localization Modality: U/S Mamm

Injection Location: MIC Hospital

Was breast MRI performed? Y N

Most recent mammogram images (CC/ML or MLO) date _____

Where was the most recent mammogram performed? _____

ALL mammogram /MRI/Pathology/Biopsy reports attached? Y N

Surgery Date:_____ Surgery Time: _____ Loc Time: _____

Injection Time: _____ MRI Date: _____

PT.

MR#/RM.

DR.