

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: Breast Center Hospital

Localization Modality: U/S Mamm

Injection Location: Breast Center 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.