McLaren CLARKSTON | DOING WHAT'S BEST.

MAMMOGRAPHY ORDER FORM

Patient Name: ______________________ DOB: __________ Today's Date: __________
Patient Phone Number: ______________________ Referring Physician: ______________________
Physician Signature (Mandatory): ______________________
Office Phone Number: ______________________ Office Fax Number : ______________________
Previous Mammogram: [] Yes [] No If yes, where: ______________________

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Screening Mammogram (Asymptomatic):

[] 2D Mammogram
[] 3D Mammogram *(may not be covered by all insurance(s))*

Diagnostic Mammogram (Symptomatic)***:

(with Ultrasound if needed)

[] 2D Bilateral Diagnostic
[] 2D Unilateral Diagnostic *[] Right [] Left*
[] 3D Bilateral Diagnostic
[] 3D Unilateral Diagnostic *[] Right [] Left*

Diagnostic Ultrasound (Symptomatic)***:

(with Mammogram if needed)

[] Bilateral Diagnostic Complete
[] Bilateral Diagnostic Limited
[] Unilateral Diagnostic Complete *[] Right [] Left*
[] Unilateral Diagnostic Limited *[] Right [] Left*

*****Please indicate symptom(s) for Diagnostic:**

[] History of Breast Cancer
[] Nipple Discharge/Discoloration
[] Palpable Lump or Mass
[] Skin Dimpling or Thickening
[] Breast Pain or Tenderness
[] Calcifications
[] Abnormal Mammogram/Additional View
[] Short Term Follow up
[] Other: ______________________

Comment(s):

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On the day of your mammogram appointment, please do not use powder, lotion, or wear deodorant.

**** The CPT code for 2D screening is 77067 with the additional CPT code of 77063 for 3D technology.***

*****The CPT code for a 2D diagnostic study is 77066 with the additional CPT code of G0279 for 3D diagnostic technology.***

****Attention Ordering Physician(s) ****

[] *Check here if any additional Diagnostic studies and/or procedures listed below may be performed under the discretion of the Radiologist prompted by an abnormal screening mammogram.*

Please check below if you want one or more of the following studies and/or procedures only:

[] Additional Diagnostic Images and Ultrasound
[] Breast Ultrasound Guided Biopsy *[] Right [] Left*
[] Breast Stereotactic Biopsy *[] Right [] Left*
[] Breast Cyst Aspiration *[] Right [] Left*
[] Galactogram *[] Right [] Left*
[] Needle Localization *[] Right [] Left*

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[] Bone Density (DEXA Scan):

Diagnosis: ______________________
Reason for DEXA: [] Post-Menopausal [] Osteoporosis
Date of last DEXA: ______________________
Location of last DEXA: ______________________

Please wear loose comfortable clothing with no metal snaps or zippers.

Thank you for your Referral!

McLaren Breast Center
5701 Bow Pointe Dr.
Suite • 255 • Clarkston, MI 48346
Phone: 248-922-6810
Fax: 248-922-6811

McLaren Oakland Central Scheduling
Phone: 800-625-2736
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