McLaren Flint
FLINT, MICHIGAN

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

Department of Radiology

Date: ____ / ____ / ___ Time: _________________

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

Physician Requesting: ______________________________________ Fax: ____________________

Exam: ____

Reading:

____

____

____

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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: _________________

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22007 (11/14)

680

PT.

MR#/RM.

DR.