

**MCLAREN BAY REGION  
DIAGNOSTIC CENTER FOR WOMEN**

3175 W. PROFESSIONAL DRIVE, BAY CITY, MICHIGAN 48706  
PHONE (989) 667 6350 FAX (989) 667 6359

**ORDER FORM**

PATIENT NAME:	DOB:
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APPOINTMENT DATE/TIME:	DIAGNOSIS/REASON FOR EXAM:
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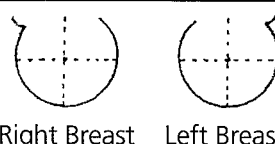
**PATIENT INSTRUCTIONS**

1. PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT IN ORDER TO AVOID ANY POSSIBLE DELAY.
2. PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TIME FOR REGISTRATION.
3. **FOR MAMMOGRAMS:** DO NOT USE DEODORANT, LOTION, OR POWDER THE DAY OF YOUR MAMMOGRAM.

**ORDERS AND DIAGNOSIS**

<p><b>Mammography</b></p> <input type="checkbox"/> Bilateral Screen (see also high risk below) <input type="checkbox"/> Bilateral Diagnostic <input type="checkbox"/> Uni. R Diagnostic <input type="checkbox"/> Uni. L Diagnostic <input type="checkbox"/> Uni. R Screen BRCA>5yr <input type="checkbox"/> Uni. L Screen BRCA>5yr Diagnosis _____	<p><b>CPT</b></p> G0202 G0204 G0206RT G0206LT G0202RT52 G0202LT52	<p><b>Fine Needle Aspiration</b></p> <input type="checkbox"/> Right 10022 <input type="checkbox"/> Left 10022 Diagnosis _____
<p><b>Breast Ultrasound</b></p> <input type="checkbox"/> Bilateral 76645 <input type="checkbox"/> Uni. Right 76645 <input type="checkbox"/> Uni. Left 76645 Diagnosis _____		<p><b>Stereotactic Biopsy</b></p> <input type="checkbox"/> Right 77031RT <input type="checkbox"/> Left 77031LT <input type="checkbox"/> Bilateral 77031 Diagnosis _____
<p><b>Needle Placement</b></p> <input type="checkbox"/> Right 77032RT <input type="checkbox"/> Left 77032LT Diagnosis _____		<p><b>Ultrasound Guided Core Biopsy</b></p> <input type="checkbox"/> Right 76942RT <input type="checkbox"/> Left 76942LT <input type="checkbox"/> Bilateral Diagnosis _____
<p><b>Ductogram/Galactogram</b></p> <input type="checkbox"/> Right 77053RT <input type="checkbox"/> Left 77053LT <input type="checkbox"/> Multi Right 77054RT <input type="checkbox"/> Multi Left 77054LT Diagnosis _____		<p><b>DEXA/Bone Density Scan</b></p> <input type="checkbox"/> Standard (Spine L1-L4 and hip) <input type="checkbox"/> Forearm Diagnosis: ___ Osteoporosis, drug induced      ___ Osteopenia ___ Osteoporosis, unspecified      ___ Asymptomatic ___ Cushing's syndrome      ___ Postmenopausal ___ Disorder of bone and cartilage, unspecified

**Additional information for the Radiologist:**



**High Risk Evaluation Clinic for Breast Cancer**  
 We are pleased to offer immediate reads of digital screening mammograms and evaluation by a surgical breast specialist for high risk patients. This may include women with a previous diagnosis of breast cancer unless this is performed for additional workup which should be ordered as diagnostic imaging above.

**Please indicate what qualifies this patient for high risk screening (patient must meet at least 1 criteria)**  
 \_\_\_ Previous history of breast cancer    \_\_\_ 1st degree, family history of breast cancer    \_\_\_ History of breast biopsy    \_\_\_ Genetic mutation in family  
 \_\_\_ Gail Model revealing 1.5x average 5-year risk

**CALL (989) 667 6350 TO SCHEDULE THIS HIGH RISK SERVICE**

HIGH RISK CLINIC MAMMOGRAM APPOINTMENT \_\_\_\_\_

HIGH RISK CLINIC SURGICAL BREAST SPECIALIST APPOINTMENT \_\_\_\_\_  
 (appointments for high risk clinic must be on the same day)

**Check here if the patient is already being followed by a Surgeon or otherwise does not wish to see the Breast Surgeon.**

Ordering Physician	Signature (required)	Copy of reports to:
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ADDRESSOGRAPH



100B

ORDER FORM