WhidbeyHealth

Dexa – Bone Density, Breast Imaging and Biopsy Order Form

Scheduling Line: (360)678-7607
(M-F 8am-5pm, Sat. 8am-4pm)
Fax: (360)678-7652

Date and Time of Exam: _____ MRN: _____

PATIENT DATA

LAST NAME FIRST NAME MI

DOB TELEPHONE

PROCEDURE INFORMATION

Insurance:

Authorization #:

Diagnosis/Signs/Symptoms to indicate reason for the procedure: _____

_____

☐ **DEXA – BONE DENSITOMETRY**

SCREENING: ☐ Post Menopausal ☐ Osteopenia ☐ Osteoporosis ☐ Other: _____

ANNUAL SCREENING MAMMOGRAM - ASYMPTOMATIC PATIENTS

☐ Bilat. ☐ Unilat. ☐ **Right** ☐ **Left**

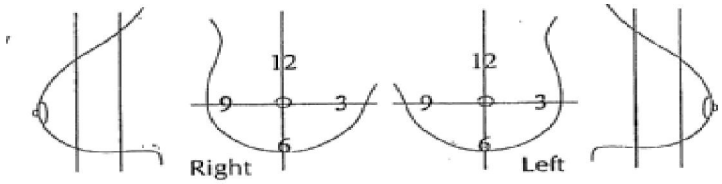
MAMMOGRAM - SYMPTOMATIC PATIENTS

☐ Bilat. Diagnostic Mammo ☐ Unilat. Diagnostic Mammo ☐ **Right** ☐ **Left** ☐ Addit'l Special View Diag Mammo ☐ Right ☐ Left

☐ Breast Ultrasound if indicated ☐ **Right** ☐ **Left**

(For any questions, please contact the Diagnostic Imaging Radiologist @ 360-678-7607 option 7)

AREA OF CONCERN MUST BE MARKED



SHORT INTERVAL FOLLOW-UP IMAGING:

☐ 6 month Diagnostic Mammogram followup ☐ **Right** ☐ **Left** ☐ 6 month Breast Ultrasound follow up ☐ **Right** ☐ **Left**

DIAGNOSTIC MAMMOGRAM: History of Breast Cancer (year diagnosed) _____

☐ 6 month follow-up post lumpectomy (for 2 years post procedure) ☐ **Right** ☐ **Left**

☐ Diagnostic mammogram post lumpectomy (for 5 years post procedure) ☐ **Right** ☐ **Left**

INTERVENTIONAL BREAST PROCEDURES:

☐ Stereotactic Breast Biopsy ☐ **Right** ☐ **Left**

☐ Sentinel Lymph Node Procedure ☐ **Right** ☐ **Left**

☐ Ultrasound Guided Breast Biopsy ☐ **Right** ☐ **Left**

☐ MRI Guided Core Breast Biopsy ☐ **Right** ☐ **Left**

☐ Cyst Aspiration of Breast (Core Biopsy if unsuccessful) ☐ **Right** ☐ **Left**

☐ Wire Localization with Mammography or Ultrasound Guidance ☐ **Right** ☐ **Left**

Provider Signature: _____ **Date/Time:** _____

Printed Name of Ordering Provider: _____

Demographic Label

7139-000954-1016

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