RADIOLOGY REFERRAL FORM - BREAST

TRA MEDICAL IMAGING

Appointment

Exam: ______________________ Date: ______________________

Time: ______________________ ❑ Call patient to schedule ❑ Patient will call to schedule

Patient Information

Date: ______________ Referring Provider: ______________________

Patient Name: ______________________ D.OB.: ______________

Phone: ______________ Interpreter Needed (language): ______________

Height: ________ Weight: ________ Pregnant: ❑ Yes ❑ No Allergies: ______________

Breast Cancer History: ❑ LT ❑ RT Mastectomy History: ❑ LT ❑ RT

Implants: ❑ Yes ❑ No Primary Care Provider: ______________________

Written Diagnosis/Reason/Symptom for Exam(s) - REQUIRED

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Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. ***Rule out, Possible or Probable Conditions cannot be coded.*** *For Medicare Policy information see the Part B Bulletin or noridian.com/medweb*

Report

Call STAT: (______) ________ - ______________

Fax STAT: (______) ________ - ______________

Fax Routine: (_____) ________ - ______________

Additional Report to: ______________________

Images

❑ CD ROM ❑ Web PACS

❑ CMC PACS ❑ Providence PACS

❑ Deliver to my office

❑ Send with patient

Insurance Information *(Send copy of patient's insurance card when faxing this referral)*

Insurance(s): ______________________

Authorization #: ______________________

Prior Exams

Date	Facility Location
________	______________________
________	______________________

SCREENING SERVICES

Mammography

Date of last mammogram: ______________________

Mammogram (asymptomatic): ❑ LT ❑ RT

Bone Densitometry (DEXA)

❑ Spine and Femur

❑ Other: ______________________

DIAGNOSTIC SERVICES

❑ Mammogram (symptomatic): ❑ LT ❑ RT ❑ BILAT

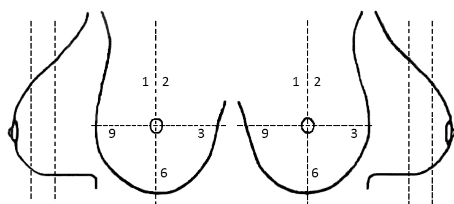
(*Ultrasound if needed*)

❍ Needle biopsy if indicated

❑ Needle Loc/Placement: ❑ LT ❑ RT ❑ BILAT

❑ Stereotactic Breast Biopsy: ❑ LT ❑ RT ❑ BILAT

Indicate area of concern:



Ultrasound

❑ Breast (limited): ❑ LT ❑ RT ❑ BILAT

❑ Breast (complete): ❑ LT ❑ RT ❑ BILAT

❑ Breast Cyst Aspiration: ❑ LT ❑ RT ❑ BILAT

❑ Guided Breast Biopsy: ❑ LT ❑ RT ❑ BILAT

Document Palp Abn: ______________________

O'clock: ______________ N+: ______________

❑ Radiologist may change order: ❑ Yes ❑ No

❑ Can perform additional imaging as needed per protocol: ❑ Yes ❑ No
(i.e. additional views, follow-up ultrasound, etc.)

MRI

Patient has a pacemaker or implanted device: ❑ Yes ❑ No

Creatinine/GFR: ______________ Date Drawn: ______________

❍ Creatinine blood draw at radioloist's discretion

❑ Breast MRI bilat with contrast

❍ Limited Chest MRI if indication (radiologist's discretion)

❑ Breast MRI Guided Breast Biopsy: ❑ LT ❑ RT ❑ BILAT

Referring Provider Signature (Required for exam) ⟶ ______________________________

EXAM LOCATION GRID

Preparing for your mammogram: wear a two-piece outfit; do not wear powder, deodorant, or lotion to exam.

Location	Bone Densitometry	Mammogram Screening	Mammogram Diagnostic	Breast Ultrasound	Needle Localization	Breast Biopsy	Galactogram	Breast MRI	Breast Cyst Aspiration
BONNEY LAKE									
Diagnostic Imaging Northwest **Bonney Lake Imaging Center** 21110 SR 410 E, Ste 110 Bonney Lake WA 98391	●	●	●	●					
OLYMPIA									
TRA Medical Imaging **TRA Olympia - on Lilly** 500 Lilly Rd NE, Ste 160 Olympia WA 98506	●	●	●	●	●	●	●	●	
PUYALLUP									
Diagnostic Imaging Northwest **Puyallup Imaging Center** 222 15th Ave SE Puyallup WA 98372	●	●	●	●	●	●	●	●	
Diagnostic Imaging Northwest **Sunrise Imaging Center** 11212 Sunrise Blvd E, Ste 200 Puyallup WA 98372	●	●	●	●					
TACOMA									
Carol Milgard Breast Center 4525 S 19th St Tacoma WA 98405	●	●	●	●	●	●		●	●

CONTACT INFORMATION

Diagnostic Imaging Northwest:
Phone: 253-841-4353
Fax: 253-446-3973

TRA Medical Imaging:
Pierce Phone: 253-761-4200
Pierce County Fax: 253-761-4201
Thurston County Phone: 360-413-8383
Thurston County Fax: 360-413-8323

Carol Milgard Breast Center:
Phone: 253-759-2622
Fax: 253-572-4324