Dartmouth-Hitchcock One Medical Center Dr., Lebanon, NH 03766 ***Diagnostic Radiology***	NAME: DOB: MRN:

BREAST IMAGING REQUEST FORM

Please fill in form completely and fax to the Mammogram Department: (603) 640-1944
Mammography Scheduling: (603) 650-8260

❑ Patient on precautions ❑ Patient is or may be pregnant

❑ O2 ❑ Wheelchair ❑ Other mobility issues_____

Other patient notes:

_____

_____

ORDER REQUEST DETAILS – SCREENING

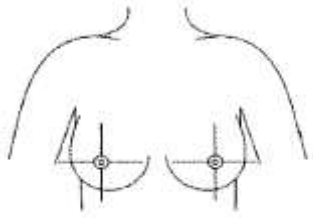
RELEVANT HISTORY:

ICD 10 _____

Date & location of last exam: _____

Implants: ❑ Yes ❑ No

ORDER REQUEST DETAILS – DIAGNOSTIC



CLINICAL HISTORY:

ICD 10_____

Clinical Concerns: _____

Quadrant: _____

Distant from Nipple: _____ Size: _____

Laterality: _____

Length of Concern: _____

Date & Location of last exam: _____

PT under 25 schedule US only

REFERRING PROVIDER

_____ _____

Physician Signature Date/Time

_____ _____

Print Physician Name Pager/Phone Number

Health Information Services Approval: 3/7/18 Scan to: Orders – Provider Care