SRC
Salem RADIOLOGY
CONSULTANTS, P.C.

Breast Imaging Referral
Mammography - Ultrasound - MRI

2925 Ryan Drive SE • Salem, OR 97301
Phone: 503.399.1262 • Fax: 503.371.0777

Patient Name: _____ DOB: _____

Appointment Date: _____ Time: _____

Ordering Physician: _____

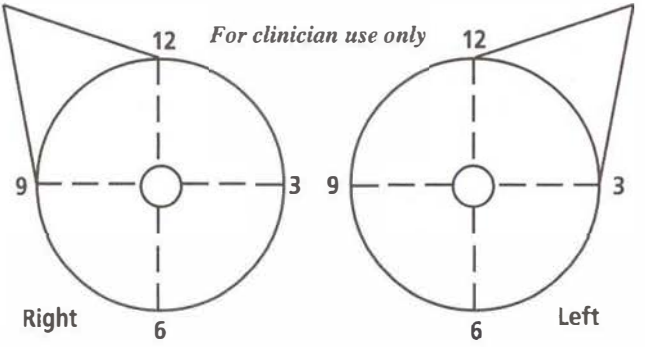
Date and location of last mammogram: _____

❑ Fax Report

Additional Comments: _____

The American Cancer Society, American College of Radiology, National Women's Health Information Center (US Department of Health and Human Services) recommends annual screening mammography beginning at age 40 for women with normal risk. There is no well-established upper age limit for screening mammography. Women with a first degree relative with breast cancer (mother, sister or daughter) should begin screening 10 years prior to her relative's diagnosis.

For clinician use only



Please indicate area of focal abnormality and approximate distance from the nipple (cm) or area of abnormality in tail of the breast.

Mark Appropriate Exam and Reason Ordered

Diagnostic Mammogram

❑ **Lump or mass** (N63)
❑ **Previous history of breast cancer** (Z98.86)
❑ **Follow-up to abnormal mammogram** (R92.2, R92.8
❑ **Nipple discharge** (N64.52)
❑ **Other** _____

Screening Mammogram

❑ **No Symptoms** (Z12.39)

❑ **Please do ultrasound if the radiologist feels it is clinically indicated**

Patient Information

Before your appointment, please complete the patient information, and bring it with you for your appointment. Please arrive 15 minutes before your scheduled time.

Patient's Name: _____ Sex: ○ M ○ F
Mailing Address: _____ Apt.#: _____
City: _____ State: _____ Zip: _____
Phone (home): _____ Age: _____ Birthdate: _____
Phone (work): _____ S.S.#: _____

Primary Insurance Co.: _____
Insured's Employer: _____
Group #: _____ ID #: _____
Insured's Name/Guarantor: _____

Secondary Insurance Co.: _____
Insured's Employer: _____
Group #: _____ ID #: _____
Insured's Name/Guarantor: _____

Date of next appointment with your physician: _____

AUTHORIZATION FOR RELEASE OF INFORMATION. I authorize Salem Radiology Consultants to release from my medical record any information required by my insurance carrier or any person, company, or agency responsible for processing my claims for medical services. I also authorized the release of protected Health information for purposes of treatment, payment and health care operations.
FINANCIAL ARRANGEMENTS. I authorize payment directly to Salem Radiology Consultants of all insurance or health plan benefits otherwise payable to me, to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance or other agency, and for any co-pays, deductibles and / or coinsurance.

Signed: _____ **Date:** _____

Reminder! **Do not wear deodorant or body powder on day of mammogram. For your convenience wear a two-piece outfit. Allow at least 1/2 hour for your appointment.**

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