Providence
Imaging Center

Phone 907-212-3151
Fax 907-212-5828

ALASKA RADIOLOGY ASSOCIATES

Today's Date

Patient Information:

Last Name | First Name | M

DOB

Patient Phone Number

☐ Male ☐ Female

Pregnant ☐ Yes ☐ No

- i = if indicated
- Imaging recommendations by radiologist. Only tests that are indicated will be completed.
- For patients presenting with clinical breast problem of one breast and is due for annual screening mammogram within 3 months recommend ordering bilateral diagnostic mammogram.
- First Degree relative with breast cancer diagnosed before age 50, start screening mammograms 10 years prior to age of diagnosis.

	Screening Mammogram	Diagnostic Mammogram	Breast Ultrasound	Screening Breast MRI	Diagnostic Breast MRI	Comments
>40 Asymptomatic	X					Annual screening mammograms
<30 Symptomatic		i	X			Bilateral diagnostic mammogram if indicated
Palpable Lump/Mass		X	X			<30 Ultrasound first, >30 Mammogram first
Breast pain		X	i			
Nipple Discharge		X	i			
Skin Changes (Dimpling, Retraction, Nipple Inversion, Rash)		X	i			
Male with Breast Symptoms		X	i			Bilateral diagnostic mammogram first
Breast Implants, Integrity					X	
High Risk	X			X		Alternate every 6 months

ICD-10 codes that support clinical Terms/History/Symptoms

- ❑ Z12.31: Screening mammogram for breast cancer
- ❑ R92.8: Abnormal screening mammogram
- ❑ Z85.3: History of breast cancer
- ❑ N63.10: Right breast mass/lump
- ❑ N63.20: Left breast mass/lump
- ❑ N64.59: Abnormal breast exam
- ❑ Other: _____

Clinical Terms/History/Symptoms: include Specificity requirements, i.e. laterality, location, underlying disease, etc. that support ICD-10 codes:

- ❑ Pathology: _____
- ❑ Family history of breast cancer
- ❑ Personal history of breast cancer
- ❑ Implants
- ❑ Other: _____

Clinician Information

Ordering Clinician:_____
Clinician Phone:_____
Clinician Fax: _____
Send Additional Copies of report to:
_____

Notes: _____

Clinician Signature:

_____

Order Selection

	Right	Left
❑ Screening		
❑ Diagnostic Bilateral Mammogram		
❑ Diagnostic Unilateral Mammogram	❑	❑
❑ Diagnostic Mammogram (<30)	❑	❑
❑ Breast Ultrasound	❑	❑
❑ Breast Ultrasound Biopsy	❑	❑
❑ Breast Ultrasound Aspiration	❑	❑
❑ Sterotactic Biopsy/Tomo Biopsy	❑	❑
❑ Ductogram	❑	❑

Breast MRI - Special Order form Required. Call 212-2879

- ❑ Clip Bracketing ❑ ❑
- ❑ Wire ❑ ❑
- ❑ SAVI SCOUT ❑ ❑
- ❑ Other_____
- ❑ Number of Wires Needed _____
- ❑ Methylene blue requested? Yes❑ No❑
- ❑ Specimen Radiograph Yes❑ No❑
- ❑ Sentinel Node Mapping (with Technetium) Yes❑ No❑
- ❑ Location of Injection Periareolar❑ Peritumoral❑
- ❑ Palpable Area Present Yes❑ No❑
- ❑ Axilla Marked Yes❑ No❑

* Indicate location of abnormality

Surgery Date and Time:
(If Applicable)