Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

BREAST IMAGING REQUEST

Please complete and fax to **(603)-640-1944**
For telephone assistance: **(603)-650-8260**

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Special Considerations: MRN:_____

- ☐ Blind
- ☐ Deaf
- ☐ Diabetic
- ☐ Disoriented
- ☐ IV
- ☐ O^2
- ☐ Pregnant
- ☐ **Precautions**
- ☐ Stretcher Needed
- ☐ Wheelchair Needed

Notes: _____
_____
_____

Patients Under 25: Schedule Ultrasound Only
Patients Over 25: Requires a Mammogram with an Ultrasound

ORDER REQUEST DETAILS - SCREENING

Relevant History*:_____

Date of Last Mammogram*:_____/_____/_____ Location of Last Mammogram*: _____

ICD 10 Code*: _____ **Code Description*:** _____ Implants*: ☐ Yes ☐ No

ORDER REQUEST DETAILS - DIAGNOSTIC

ICD 10 Code*: _____ **Code Description*:** _____

Date of Last Mammo*:_____/_____/_____

Location of Last Mammogram*: _____

Clinical Concerns*: _____

_____

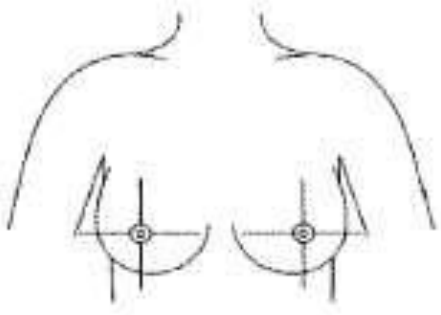
Quadrant*: _____

Distance from Nipple*: _____

Size*: _____

Laterality: _____

Length of Concern*: _____



*Mark area of clinical concern

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____

Ordering Provider Name (Print): _____

- ☐ Staff Physician
- ☐ Resident/Other

Ordering Provider Signature*: _____ Date: _____/_____/_____

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***If last mammography was done outside DHMC facility, previous 3 years of imaging is required in order to schedule.**