SANTA FE IMAGING

Requisition for Mammography, Ultrasound, & Bone Densitometry

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www.santafeimaging.com

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ SEX: ❑ M ❑ F

How can SFI reach the patient? H _____ W _____ Cell _____

Insurance Information: Primary _____ Policy # _____

Secondary _____ Policy # _____

PHYSICIAN INFORMATION

PHYSICIAN/PROVIDER NAME: _____ Phone: _____

Date: _____ Physician Signature: _____

Other Physicians who should receive a copy of the exam report: _____

❑ Routine ❑ STAT *# to call with STAT report:* _____

BREAST IMAGING

● **SCREENING MAMMOGRAM: asymptomatic / no known issues**

❑ Unilateral ❑ Bilateral ❑ Diagnostic Mammogram/US per radiologist

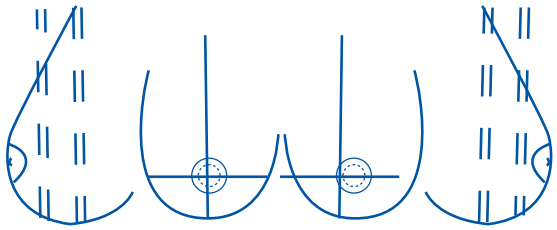
● **DIAGNOSTIC MAMMOGRAM/ULTRASOUND: symptomatic**

DIAGNOSTIC MAMMOGRAM:

❑ Right ❑ Left ❑ Bilateral ❑ Ultrasound if indicated

1) Show area for attention on diagram →

Please also give estimated distance from nipple



2) Describe problems, concerns, issues: _____

DIAGNOSTIC BREAST ULTRASOUND:

❑ Right ❑ Left ❑ Bilateral ❑ Mammogram if indicated _____

Per NCCN guidelines: It is recommended that a patient over 30 yrs receive both Mammogram and Ultrasound.

● **BIOPSY:**

❑ STEREOTACTIC BREAST BIOPSY: ❑ RIGHT ❑ LEFT ❑ BILATERAL _____

❑ US GUIDED BREAST BIOPSY: ❑ RIGHT ❑ LEFT ❑ BILATERAL _____

ULTRASOUND

❑ ABDOMINAL ULTRASOUND: _____

❑ PELVIC/ENDOVAGINAL US: _____

❑ OB US: ❑ 1st Trimester ❑ 2nd-3rd Trimester ❑ Twins/multigest _____

BONE DENSITY

❑ BONE DENSITOMETRY: Purpose & Instructions: _____

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