8516 S. Portland Ave
Oklahoma, OK 73159

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PREMIER
BREAST HEALTH INSTITUTE
OKLAHOMA

Patient Name: _____ **Referring Provider:** _____

Patient Date of Birth: _____ **Provider Phone:** _____

Appointment type: _____ **Provider Fax:** _____

Appointment Date/Time: _____

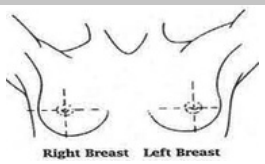
SCREENING EXAMINATION

Exam Type	Indication
☐ Screening Mammography- *with additional diagnostic mammography and/or breast ultrasound, if indicated*	☐ Screening for Breast Cancer (Z12.31)
☐ Screening Whole Breast Ultrasound	☐ Dense Breast Tissue (R92.2)
	☐ Family History of Breast Cancer (Z80.3)

BONE DENSITOMETRY

Exam Type	Indication	
☐ Axial DEXA Bone Densitometry- with TBS at radiologist's discretion	☐ Screening for osteoporosis (Z13.280)	☐ Other specified menopausal and perimenopausal disorder (N95.8)
☐ Whole Body Composition	☐ HX of osteoporosis/osteopenia (Z79.83)	☐ Other specified disorder of bone density and structure (M85.88)
	☐ Other:	

DIAGNOSTIC EXAMINATIONS

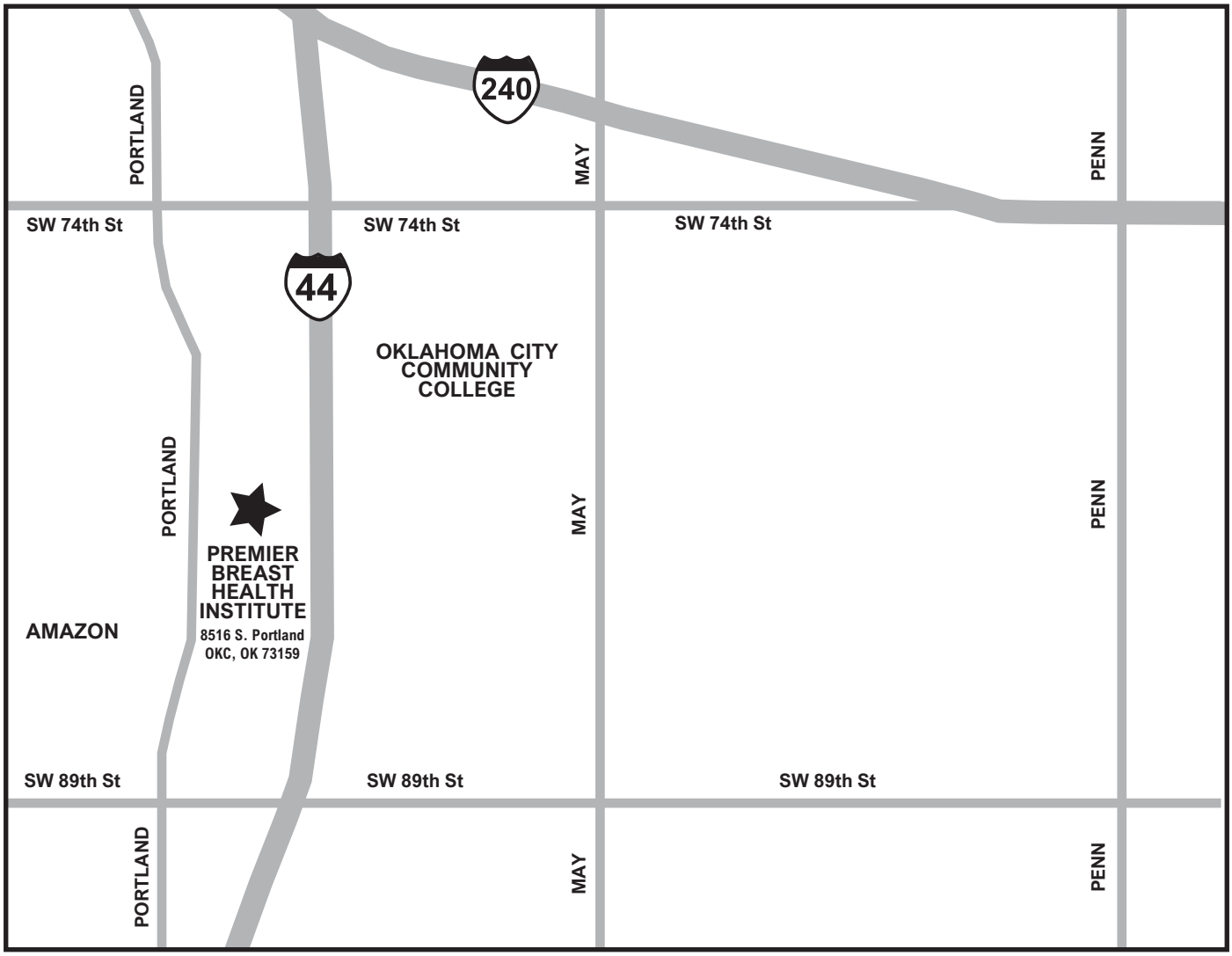


Describe the clock or quadrant location:

_____

Exam Type	Right Breast	Left Breast	Indication
☐ Diagnostic Mammography - *order to proceed with breast ultrasound &/or image guided biopsy, if indicated*	☐	☐	☐ Cyst- (N60.0)
☐ Breast Ultrasound - *with elastography at radiologist discretion, order to proceed with image guided biopsy, if indicated*	☐	☐	☐ Lump/Mass- (N63)
☐ Breast Biopsy- *(Stereotactic, Ultrasound, MRI, Contrast Enhanced Mammography)*	☐	☐	☐ Pain- (N64.4)
☐ Breast Aspiration	☐	☐	☐ Personal History of Breast Cancer- (Z85.3)
☐ Breast MRI - *w/wo contrast*	☐	☐	☐ Breast Cancer- Newly Diagnosed- (C50.919)
☐ Breast MRI - *Implant Integrity (without contrast)*	☐	☐	☐ Implant Problem- (T85.41XA)
☐ Breast MRI- *Abbreviated (dense breast tissue or risk less than 20%, Screening)*	☐	☐	☐ Nipple Discharge- (N64.52)
☐ Contrast Enhanced Mammography	☐	☐	☐ Nipple Retraction- (N64.53)
☐ Needle Localization with Image Guidance	☐	☐	☐ Abnormal Imaging/Additional work up needed- (R92.8)
☐ Interpretation of Outside Images- *with orders to proceed with mammography, ultrasound &/or biopsy, if indicated*	☐	☐	☐ Other:

Ordering Provider's Signature: _____ Date: _____



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