

PHYSICIAN'S INFORMATION - To be completed by doctor's office and signed by ordering physician, or attach Dr.'s signed prescription.
STUDY TYPE (Please check one):

Today's Date: _____

- Breast MR
 Breast Implant Study
 Breast Biopsy
 Chest MRI should be included if known breast cancer
 Computer Aided Detection (CAD) is a necessary diagnostic tool added to all breast studies.

 PRINT Dr.'s name: _____ **▶ DR.'S SIGNATURE:** _____

Dr.'s office contact person _____ Ph#: (____) _____ FAX#: (____) _____

CC report to: _____

REASON FOR EXAM CPT: _____ ICD-9: _____, CPT: _____ ICD-9: _____

- | | |
|---|--|
| <input type="checkbox"/> Screening, no problems or symptoms | <input type="checkbox"/> Breast pain (<input type="checkbox"/> right <input type="checkbox"/> left) |
| <input type="checkbox"/> Known recent/current breast cancer (<input type="checkbox"/> right <input type="checkbox"/> left) | <input type="checkbox"/> Follow-up to previous MRI |
| <input type="checkbox"/> Breast lump or thickening (<input type="checkbox"/> right <input type="checkbox"/> left) | <input type="checkbox"/> Implant problem (<input type="checkbox"/> right <input type="checkbox"/> left) |
| <input type="checkbox"/> Nipple discharge or abnormality (<input type="checkbox"/> right <input type="checkbox"/> left) | <input type="checkbox"/> Neoadjuvant therapy follow-up |
| <input type="checkbox"/> Enlarged lymph glands under arm (<input type="checkbox"/> right <input type="checkbox"/> left) | <input type="checkbox"/> Other: _____ |

PATIENT HISTORY

- Is patient currently pregnant or breast-feeding? Yes No
 Is patient still menstruating? Yes No If yes, first day of last period ___/___/___ Normal cycle (days from one period to next): _____
 Does patient take hormones? (birth control or hormone replacement) Yes No Type: _____ When did they stop? ___/___/___
 Does patient have a breast expander in place? Yes No (right left)
 Family history of breast cancer? Yes No If yes: Mother Aunt Sister Grandmother Daughter
 History of breast cancer gene carrier? Yes No Never tested
 History of radiation treatment? Yes No If yes, at what age: _____ For what: _____
 Previous mammogram: Yes No Date ___/___/___ Where? _____
 Previous ultrasound: Yes No Date ___/___/___ Where? _____

Has patient had any of the following?

	Left	Right	DATE & RESULTS
Cyst aspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needle biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgical biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lumpectomy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Implants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast reduction surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____

IF HAVING CONTRAST - DOES PATIENT HAVE:

- Kidney problems/Renal disease** Yes No
Hepatic disease/past or pending liver transplant Yes No
Rx for Hypertension Yes No
Rx for Diabetes Yes No | **Age >60** Yes No
 If Yes to any, require lab information within last 45 days:
 BUN _____ Cr _____ GFR _____ Date: _____
 Location: _____
 OK to provide i-Stat lab test at OAI if needed Yes No

PATIENT INFORMATION

Name: _____ DOB: _____ SS#: _____ Wt: _____ Ht: _____

Home Ph#: _____ Work/Cell #: _____ City: _____

INSURANCE INFORMATION
Primary insurance: _____ Subscriber: Self Other: _____

 Policy #: _____ Group #: _____ **Authorization necessary?** Yes No

AUTHORIZATION #'s: _____
 Auth. valid from _____ to _____

 { Due to pre-auth requirements by most insurance companies
 please provide CPT and ICD-9 #s above.

Other insurance: _____ Subscriber: Self Other: _____

 Policy #: _____ Group #: _____ **Authorization necessary?** Yes No

form # OAIbreastMRI - rev. 3/09
APPOINTMENT INFORMATION - To be completed by ordering physician staff.

Follow-up Appointment with Doctor (Name): _____

 DATE: ___/___/___ TIME: _____ AM PM (Initials: _____ Date: _____)