



MRI Scheduling (907) 212-3146 phone, 212-5828 fax
Other Scheduling (907) 212-3151 phone, 212-5828 fax
 or toll-free (888) 458-3151
PIC Nurse (907) 212-3607
Biopsy Line (907) 212-5856, 212-5828 fax

Request for Special Breast Procedures

PATIENT LAST NAME	FIRST	M	PT. PHONE NUMBER	DATE OF BIRTH
ORDERING CLINICIAN			CLINICIAN SIGNATURE	
SEND ADDITIONAL COPIES OF REPORT TO				
CLINICAL DATA INDICATING MEDICAL NECESSITY				

Breast MRI

Reason for MRI Request (check one):

(Please forward any outside mammogram films/reports)

- Implant integrity or suspected implant rupture
- Surgical planning for patient with known breast cancer
Date of surgery _____
- Response to neoadjuvant chemotherapy

The following require radiologist approval:

- Follow-up for breast cancer
- High Risk Patient Assessment *
- Other _____

Additional Patient Information

Height _____ Weight _____ Bra size _____

- Post-menopausal Date of last hormone use _____
Except for pre-surgical scans, all exogenous estrogen (HRT, birth control and natural formulas) must be stopped for 3 months.
- Pre-menopausal First day of LMP _____
Day 7-10 of cycle are optimal for exam. The effect of estrogen on breast tissue significantly impacts the quality of study.

* **High Risk Surveillance:** An objective quantification of lifetime risk, using one of the standard assessment models is required for these patients. This assessment may be performed by a genetic counselor or the patient's clinician. Patients with a calculated lifetime risk of >20% will be considered for surveillance with breast MRI in addition to conventional mammography. If your patient needs an appt. with a genetic counselor, one is available through the Cancer Center at Providence. Call (907) 212-2629

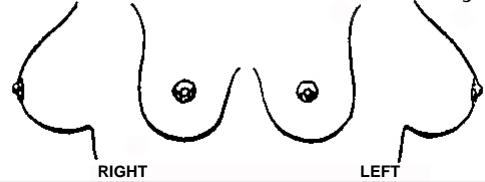
Prior breast surgery (date, type and histology please):

Date & Location of recent breast imaging studies**:

	Date	Location
Mammogram		
Ultrasound		
MRI Breast		

** Please make arrangements to have copies of the films/reports including pathology reports forwarded to PIC. Reports can be faxed to (907) 212-5828.

Indicate location of abnormality



Other Breast Imaging

Digital Mammography

- Screening
- Diagnostic Bilateral Mammogram
- Diagnostic Unilateral Mammogram R L
- Cone/Magnification Views, if needed R L
- Ductogram R L
- Have you observed discharge? (circle one) Yes / No
- Is the discharge (circle one) bloody or clear?
- How many ducts involved? (circle one) 1 2 3 4 5
- Was a smear sent to lab? Send results _____
- Is the discharge (please circle) spontaneous or expressed only ?

Ultrasound

- Breast Ultrasound only if needed R L
- Ultrasound guided breast aspiration R L

Imaging Guided Biopsies

- Stereotactic R L
- Ultrasound R L
- MRI R L

Wire Localization (check one)

- Stereotactic R L
- Ultrasound R L
- MRI R L
- Ductogram R L

Additional Info needed for Wire Localization

- Surgery Date/Time _____
 Number of wires needed _____
 Bracketing required? (circle one) Yes / No
 Methylene blue requested (circle one) Yes / No
 Specimen Radiograph (circle one) Yes / No
 Sentinel Node Mapping (with Technetium)
 Location of injection Periareolar Peritumoral
 Palpable area present? (circle one) Yes / No
 (please indicate on diagram above) EMLA Yes / No

Notes:

Tumor marker placement

- by MRI by Ultrasound by Stereotactic