Providence Imaging Center

3340 Providence Drive • Anchorage, AK 99508
www.provimaging.com

PIC Nurse
PHONE (907) 212-3607

Other Scheduling
PHONE (907) 212-3151
FAX (907) 212-5828
OR TOLL FREE (888) 458-3151

MRI Scheduling
PHONE (907) 212-3146
FAX (907) 212-5828

Biopsy Line
PHONE (907) 212-5856
FAX (907) 212-5828

Today's Date_____ **Exam Date**_____

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
  BUN/Creat. _____ Necessary for the following breast MRI studies if history of: renal disease/transplant, liver disease/transplant, HTN, diabetes, GFR under 40 within last 60 days, or age >60.
- ❑ 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.

Providence Imaging Center is an independent diagnostic testing facility that provides imaging services in Anchorage, Eagle River, and Soldotna. Rev 10/11

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? ❑ 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? ❑ Yes ❑ No
Methylene blue requested ❑ Yes ❑ No
Specimen Radiograph ❑ Yes ❑ No
❑ Sentinel Note Mapping (with Technetium)
Location of injection ❑ Periareolar ❑ Peritumoral
Palpable area present? ❑ Yes ❑ No
(please indicate on diagram above) EMLA ❑ Yes ❑ No

Notes: _____

_____

TUMOR MARKER PLACEMENT

❑ by MRI ❑ by Ultrasound ❑ by Stereotactic