



PREPARATION FOR BREAST IMAGING PROCEDURES

Mammography:

- Wear a two-piece garment and do not use talcum powder, deodorant or perfume on the day of the exam. Please bring any previous mammograms for comparison.

Breast Ultrasound:

- Wear comfortable, loose-fitting clothing. Please bring any previous breast sonograms for comparison.



**NEW YORK
RADIOLOGY
PARTNERS**

East Manhattan Diagnostic Imaging

Union Square Diagnostic Imaging

Dove Open MRI

Kingsway Diagnostic

Columbus Circle Imaging

Morningside Medical

Midtown Medical Pavilion

Central Park Women's Imaging

PREGNANCY CONSENT FORM

Date: _____

This examination requested by my physician is potentially harmful to my pregnancy, and may cause a miscarriage or congenital deformity. I understand this potential risk to the pregnancy and agree to have the examination performed as requested.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____



PATIENT SATISFACTION SURVEY

We are striving to provide you with the best possible care. Please help us to achieve this goal by taking a few minutes of your time to answer the following questions. In doing so you will help us to provide optimum care for all our patients.

Name: (optional) _____ Date: _____

Type of examination: _____

Was it easy to schedule your appointment for today's test? Yes No

If no, explain why? _____

Was your scheduler: *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

Was your examination started on time? Yes No

If not, how long did you wait for your examination:

- Less than 15 minutes
- 15 – 30 minutes
- 30 minutes or more

If more than 15 minutes, did someone explain the reason for delay? Yes No

Was your receptionist: *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

Was the technologist who performed the procedure: *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

If your exam required a Radiologist (Doctor): *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

Please rate your overall experience. *(Circle a number on the scale below to indicate your level of satisfaction)*

1 2
⏟
Poor

3 4
⏟
Fair

5 6
⏟
Satisfied

7 8
⏟
Very Satisfied

9 10
⏟
Excellent

Any additional comments that you can make would be helpful: *(The use of names would be helpful.)*

Thank you for taking the time to complete this survey.



Recommendation for Clinical Breast Examination

Dear Patients:

Please be advised that a Clinical Breast Examination* is recommended to be performed yearly by your referring doctor, nurse or nurse practitioner for patients who are 40 years or older. If you are 18 to 39 years old it is recommended to be performed at least every 3 years. If you have not had a clinical breast examination in the recommended time frame, please contact your referring physician and discuss the importance of the exam.

West Side Radiology Associates, P.C.
Effective 1/1/04

*Clinical Breast Examination is a physical examination of the breast done by a health care professional (medical doctor, nurse or nurse practitioner).

Patient's Signature: _____

Date: _____