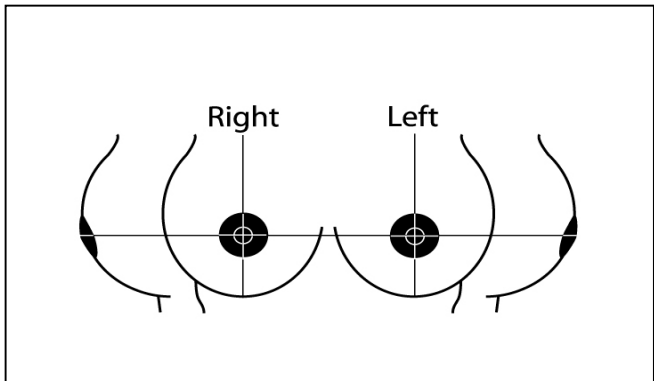




BREAST IMAGING

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax #:
Clinical History:		
Is the patient pregnant? Yes No		
Physician Signature:		Date:

<p>Please check off clinical findings:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Pain (indicate on diagram) <input type="checkbox"/> Implant Problem <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Palpable Mass (indicate on diagram) <input type="checkbox"/> Other _____ <p>Please check off procedure(s) requested:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Routine Annual Screening Mammogram <input type="checkbox"/> Recall for Abnormal Screening Mammogram <input type="checkbox"/> Breast Ultrasound: R L <input type="checkbox"/> Breast Ultrasound Biopsy: <table style="margin-left: 20px; border: none;"> <tr> <td><input type="checkbox"/> Fine Needle Aspiration</td> <td><input type="checkbox"/> Stereotactic Biopsy</td> </tr> <tr> <td><input type="checkbox"/> Vacuum Assisted Core</td> <td><input type="checkbox"/> Breast MRI</td> </tr> <tr> <td><input type="checkbox"/> Cyst Aspiration</td> <td><input type="checkbox"/> Breast MRI Biopsy</td> </tr> </table> 	<input type="checkbox"/> Fine Needle Aspiration	<input type="checkbox"/> Stereotactic Biopsy	<input type="checkbox"/> Vacuum Assisted Core	<input type="checkbox"/> Breast MRI	<input type="checkbox"/> Cyst Aspiration	<input type="checkbox"/> Breast MRI Biopsy	
<input type="checkbox"/> Fine Needle Aspiration	<input type="checkbox"/> Stereotactic Biopsy						
<input type="checkbox"/> Vacuum Assisted Core	<input type="checkbox"/> Breast MRI						
<input type="checkbox"/> Cyst Aspiration	<input type="checkbox"/> Breast MRI Biopsy						

<p>Hours of Operation:</p> <p>Monday – Thursday 8:00 am – 8:00 pm, Friday 8:00 am – 5:00pm and Saturday 8am-1pm</p> <p>Ultrasound appointments are available Monday – Friday 8am – 5pm and Saturday 8am-1pm</p> <p>To schedule an appointment please call 212.590.2900.</p> <p>Appointment Date/Time: _____ Pre- Auth# _____</p> <p>Please have your insurance card available. Please Note: Co-payments are collected at time of visit.</p>
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