MUNSON HEALTHCARE

Form 11657 (07/25)

BREAST IMAGING ORDER

Patient Legal Name: _____

Date of Birth: _____ Phone Number: _____

Location in the Breast: _____

Diagnosis: _____

STEP 1: **INITIAL BREAST IMAGING PROCEDURES:** (please check boxes as applicable)

Mammogram: ☐ **SCREENING** → ☐ bilateral ☐ unileft ☐ uniright
☐ **DIAGNOSTIC** → ☐ bilateral ☐ unileft ☐ uniright
☐ **SCREENING *WHOLE* BREAST US** → ☐ bilateral ☐ unileft ☐ uniright
☐ **DIAGNOSTIC BREAST US** → ☐ bilateral ☐ unileft ☐ uniright

BILATERAL BREAST MRI Prior Auth # _____

STEP 2: **FOLLOW-UP BREAST IMAGING PROCEDURES:**

☐ Check box if, you would like the patient to receive a diagnostic mammogram and/or ultrasound as recommended by the radiologist if any of the following are found: calcifications, asymmetry, mass (palpable or non-palpable).

- **Diagnostic Mammogram**
- **Diagnostic Breast US**
- **Diagnostic Tomography**
- **Ultrasound Axilla**
- **Ductogram**
- **Contrast Enhanced Mammogram**

STEP 3: **ADDITIONAL BREAST IMAGING PROCEDURES:**

Check the box below if your patient has a probably benign or suspicious finding as a result of the follow-up breast imaging in step 2 and you are giving permission for the following exams:

☐ **3, 6, or 12 month follow-up Mammogram and/or Ultrasound, Contrast Enhanced Mammogram, Image Guided Biopsy or Aspiration as recommended by the Radiologist.**

STEP 4: **BIOPSY RESULT PATIENT NOTIFICATION: (Only available if performed in Traverse City or Cadillac)**

☐ The Radiologist or the Mammography Staff may notify the patient with results of the radiology biopsy procedure.
☐ I prefer to contact the patient with biopsy results myself.

STEP 5: **SURGICAL CONSULT: (Only available if performed in Traverse City or Cadillac)**

☐ The Mammography Staff may schedule a surgical consultation appointment after an abnormal finding on a breast procedure, or breast imaging that may require a biopsy and is not amenable to the less invasive procedures listed above pursuant to the radiologist's standard referral procedure.

☐ Patient or PCP requests a specific surgeon here: _____

STEP 6: **Patient may be referred to High Risk Breast Cancer Clinic if Risk Score on mammography is > 20%.**

- **Patient will be involved in all decisions about their care, treatment and services provided.**
- **Breast MRI follow-up must be scheduled by the referring healthcare provider as insurance pre-authorization is required prior to the exam.**

Healthcare Provider Signature **Healthcare Provider** (Print) **Date** **Time**

*This is a conditional radiology order in compliance with Medicare Benefit Policy Manual, Chapter 15, section 80.6 (rev 10-13-16)