



Appointment Date _____ Appointment Time _____ AM/PM (Arrive 15 Minutes Early To Register)

Patient Name _____ DOB _____ Female Male Insurance _____

For Medicare Part B patients requiring a CT/MRI only, please make sure to include:

G-Code _____ HCPCS Modifier _____ Decision Support Number _____

Home# _____ Cell# _____ Work# _____

Please do not bring children needing supervision to your exam

1. DIGITAL MAMMOGRAM:

Screening Add Views: Bilat Right Left

If after the screening mammogram the radiologist recommends a diagnostic mammogram and/or breast ultrasound, do you approve these orders? Yes No

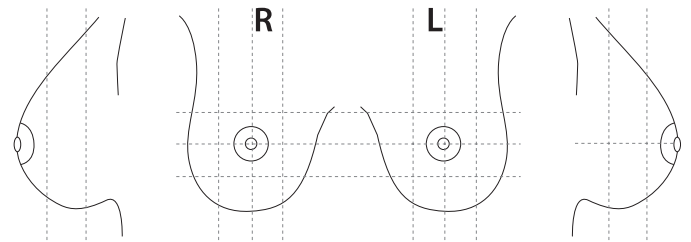
Diagnostic Add Views: Bilat Right Left

Reason for diagnostic:

- Abnormal mammogram
- Palpable mass
- Personal history or risk factors
- Other

Contrast enhanced Mammography, if needed

Breast MRI if indicated per ACR guidelines



Additional Exams or Instructions:

2. BREAST ULTRASOUND

- Supplemental Screening Ultrasound (ABUS)
- Diagnostic Ultrasound

Bilat Right Left
 Bilat Right Left

3. BREAST MRI

- Bilateral Breast MRI w/and w/o contrast
 - Bilateral Breast MRI w/o contrast (implant integrity only)
- Type of Implants: Silicone Saline

OTHER EXAMS

- Pelvic Complete Add Doppler
- Endovaginal Only Add Doppler
- OB _____ Weeks
- DEXA
- Other _____

ULTRASOUND PATIENT PREPS

- OB/Gyn and Pelvic Complete: Finish drinking 32 oz. of fluid without emptying bladder by one hour prior to exam. Bladder must be full for exam.
- Endovaginal Only: no prep required

Exam indication/ICD10: _____

Other Pertinent Information: _____

Printed Physician Name: _____ Phone Number: _____ Fax Number: _____

Physician Signature _____ Date: _____
(Must be physician signature; we no longer accept a stamped signature)

Send copy of results to: _____

- Send a Copy of Exam with patient
- Send a Copy of Exam to Ordering Physician

STAT READING YES NO Call Results Attn: _____ Phone #: _____



HIGH RESOLUTION WOMEN'S IMAGING AND MORE

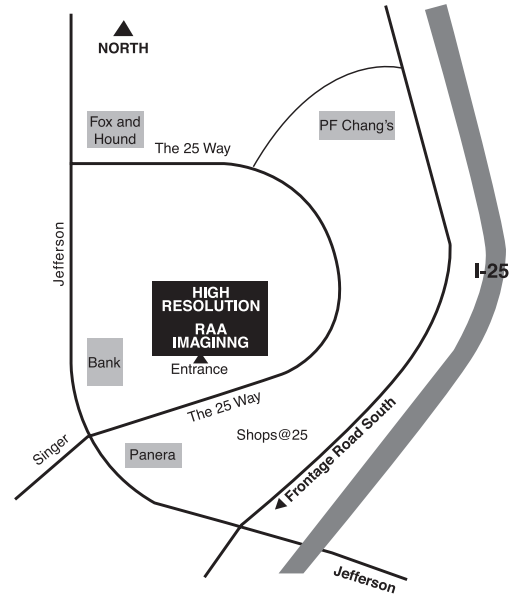
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