Beaufort Memorial HOSPITAL

MAMMOGRAM/DEXA SCAN REFERRAL FORM **Page 1 of 1**

This request for service must accompany the patient at the time of service.

☐ Elective ☐ Routine ☐ Urgent ☐ Emergency within 24 hours Pt Acct #: _____

PATIENT INFORMATION

Patient Name (Last, First, MI)

_____

Address:

_____

DOB _____ Patient SS# _____ Sex ☐ M ☐ F

GENERAL INSTRUCTIONS

All orders must include an ICD-10 code or diagnosis. Test not covered by that code, may be charged to the patient. Please fill in the appropriate code or diagnosis for each test.

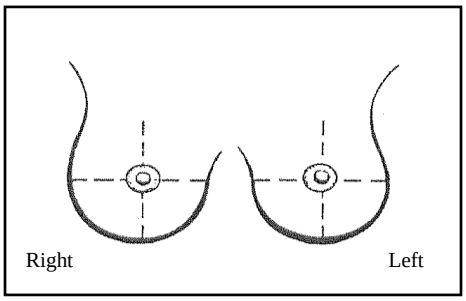
Diagnosis: (required) _____

ICD-10 Code(s) _____

******Please specify exam or procedure desired including clinical indicators******

Clinical Indicators ☐ Right ☐ Left ☐ Bilateral

- ☐ Abnormal Mammogram
- ☐ Short Term Follow-Up Mammogram (previous abnormal breast imaging)
- ☐ Personal History of Breast Cancer
  - ☐ Post Lumpectomy
  - ☐ Post Mastectomy
- ☐ Focal Breast Pain
- ☐ Breast Lump/Mass
- ☐ First Degree relative with Breast Cancer



Please use diagram to illustrate any clinical concerns or abnormality

☐ **Screening Mammography**

Screening Mammogram - asymptomatic patient with no personal history of breast cancer.

☐ **Diagnostic Breast Evaluation** (May include mammography, ultrasound and MRI as indicated by Radiologist)

May proceed with the following procedures as needed for diagnosis:

- ☐ Follow my Standing Orders on file with Breast Care Coordinator.
- ☐ I prefer the patient to see me prior to any invasive procedure.
- ☐ Please have patient consult with surgery prior to biopsy.
- ☐ Surgical evaluation for palpable abnormality.

Preferred Surgeon: Dr._____

☐ **MRI** ☐ **Breast Ultrasound** ☐ **Dexa Scan/Bone Density**

☐ **Image Guided Needle Biopsy** ☐ Right ☐ Left ☐ Bilateral ☐ Screening - every 2 years ☐ Monitoring

AUC Information **Please note: For AUC, Vendor Name (G Code) + Modifier are required**

Vendor Name (G Code) + Modifer: _____

NPI Number: _____ **Decision Support Number:** _____ **Score:** _____

Selected Procedure: _____ **Selected Indication:** _____

Consultation Results: _____

Referring Physician's Printed Name & Signature:

Name *(Please Print)* _____ **Signature:** _____

Office Address: _____ **Phone:** _____

Date / Time: _____

Revised 12.2019