

## MAMMOGRAPHY ORDER FORM

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Phone \_\_\_\_\_ Patient DOB \_\_\_\_\_

Referring Physician \_\_\_\_\_

Physician Signature \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Prior Authorization No. \_\_\_\_\_

Previous Mammogram  Yes  No  
If Yes, where/when \_\_\_\_\_

### Screening Mammogram

Please check:  Bilateral  Right  Left

- ICD-10**
- Baseline Exam .....Z12.31
  - Asymptomatic/Routine Exam .....Z12.31
  - Augmentation, No Clinical Concerns .....Z98.82

### Diagnostic Mammogram

Please check:  Bilateral  Right  Left

- History of Breast Cancer .....Z85.3
- Fibrocystic Breast .....N60.39
- Palpable Lump or Mass .....N63
- Breast Pain or Tenderness .....N64.4
- Nipple Discharge/Discoloration.....N64.52
- Short Term Follow-up
- Augmentation .....Z98.82
- Skin Dimpling or Thickening .....N64.59
- Additional Views/Abnormal Mammograms .....R92.8  
Dx \_\_\_\_\_
- Other \_\_\_\_\_

### 3D Tomosynthesis

- Unilateral Diagnostic Mammogram w/3D  
.....G0206+G0279
- Bilateral Diagnostic Mammogram w/3D  
.....G0204+G0279
- Screening Mammogram w/3D .....G0202+77063

### Bone Density

*No Vitamins or Calcium 48 hours prior to exam*

### Ultrasound

\* All Patients 28 yrs & younger must have palpable area.

\* All Patients 29 yrs & older must have a recent mammogram.

Please check:  Bilateral  Right  Left

**ICD-10**

- Breast, Palpable Area
- Breast, Abnormal Mammogram .....N63
- Pelvic
- Transvaginal
- Other \_\_\_\_\_

### MRI Breast Dx: \_\_\_\_\_

- Ruptured Implant .....T85.49XA
- BRCA1 or BRCA2 Positive

### Procedures

Please check:  Bilateral  Right  Left

Diagnosis \_\_\_\_\_

- Number of sites \_\_\_\_\_
- Stereotactic Biopsy
  - Ultrasound Guided Biopsy
  - MRI Breast Biopsy
  - Ultrasound Cyst Aspiration  Send Fluid

Allergies (Biopsy Patients Only)  Yes  No

If Yes, \_\_\_\_\_

Is the patient taking any blood thinning medications; such as Aspirin, Coumadin, Plavix, Aleve or Ibuprofen?  
If yes, please list \_\_\_\_\_ # of days off \_\_\_\_\_.

**Please send prior Mammograms, Breast Ultrasounds and Reports with the patient or forward them to our office prior to the scheduled exam for comparison. Thank you.**