



Phone: 706-507-7465

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Midtown: 1538 13th Avenue B-200; Columbus 31901
North: 3081 Williams Rd B-200; Columbus, GA 31909

Patient Name: _____

Date of Birth: _____

Screening Mammogram

Conditional Order: Additional Imaging Studies as Recommended by Radiology (To Include Diagnostic Mammogram, Diagnostic Breast Ultrasound, Breast Biopsy or Cyst Aspiration)

Diagnostic Mammogram

Conditional Order: Additional Imaging Studies as Recommended by Radiology (To Include Diagnostic Mammogram, Diagnostic Breast Ultrasound, Breast Biopsy or Cyst Aspiration)

Breast Ultrasound

Conditional Order: Additional Imaging Studies as Recommended by Radiology (To Include Diagnostic Mammogram, Diagnostic Breast Ultrasound, Breast Biopsy or Cyst Aspiration)

RIGHT LEFT

BILATERAL

RIGHT LEFT

BILATERAL

Diagnosis:

Breast Mass Right Left Bilateral

Breast Pain Right Left Bilateral

Nipple Discharge Right Left Bilateral

Other = Enter: _____

ABUS: We recommend Automated Breast US for Category C or D Density

DEXA: Default Diagnosis Post Menopausal Screening
If Other Diagnosis Please Note:

Thyroid US: Enter Diagnosis: _____

Signature

Date