

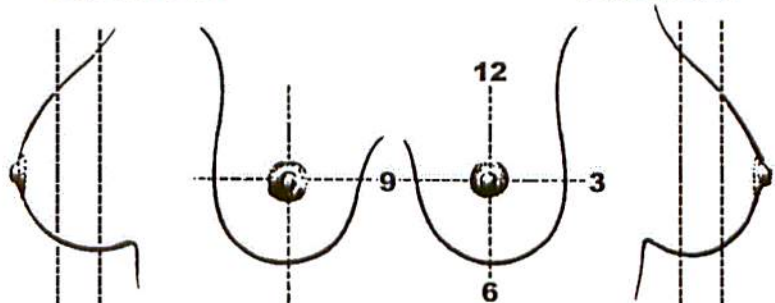
BREAST IMAGING ORDER FORM

LAST NAME		TODAYS DATE	*** ICD-10 INFO REQUIRED ***	
FIRST NAME		DATE OF BIRTH	<input type="checkbox"/> Encounter for screening mammogram for neoplasm of breast	Z12.31
PHONE		ALT. PHONE	<input type="checkbox"/> Unspecified lump in breast	N63
INSURANCE COMPANY			<input type="checkbox"/> Mastodynia	N64.4
POLICY #		GROUP #	<input type="checkbox"/> Nipple discharge	N64.52
PHYSICIAN NAME			<input type="checkbox"/> Other signs and symptoms in breast	N64.4
OFFICE TELEPHONE NUMBER			<input type="checkbox"/> Inconclusive mammogram	R92.2
PHYSICIAN SIGNATURE *** (REQUIRED)			<input type="checkbox"/> Abnormal findings on diagnostic imaging of breast	R92.8
			<input type="checkbox"/> Personal history of malignant neoplasm of breast	Z85.3
			OTHER REASONS FOR EXAM	
			SPECIAL INSTRUCTIONS	
			PRE-AUTH REQUIRED: Y <input type="checkbox"/> N <input type="checkbox"/> PRE-AUTH #	

<input checked="" type="checkbox"/>	EXAM	CPT	<input checked="" type="checkbox"/>	EXAM	CPT	<input checked="" type="checkbox"/>	EXAM	CPT
SCREENING MAMMOGRAPHY			PROCEDURES			MRI		
<input type="checkbox"/>	SCREENING MAMMOGRAM BILATERAL	G0202 77052	<input type="checkbox"/>	ASPIRATION OF CYST OF BREAST US GUIDANCE	19000 76942	<input type="checkbox"/>	MRI BREAST BILATERAL W/O & W DYE	C8908
<input type="checkbox"/>	SCREENING MAMMOGRAM UNILATERAL	G0202-52 77052	<input type="checkbox"/>	BIOPSY BREAST STEREOTACTIC GUIDANCE	19081	<input type="checkbox"/>	MRI BREAST BILATERAL W/O DYE	C8907
<input type="checkbox"/>	SCREENING MAMMOGRAM BILATERAL WITH TOMOSYNTHESIS	G0202 77063 77052	<input type="checkbox"/>	BIOPSY BREAST US GUIDANCE	19083	<input type="checkbox"/>	MRI BREAST UNILATERAL W/O & W DYE	C8905
<input type="checkbox"/>	SCREENING MAMMOGRAM UNILATERAL WITH TOMOSYNTHESIS	G0202-52 77063 77052	<input type="checkbox"/>	DUCTOGRAM	77053 19030	<input type="checkbox"/>	MRI BREAST UNILATERAL W/O DYE	C8904
DIAGNOSTIC MAMMOGRAPHY			<input type="checkbox"/>	INJECTION OF RADIOACTIVE TRACER FOR SENTINEL NODE IDENTIFICATION US GUIDE	38792 76942	OTHER EXAMS REQUESTED		
<input type="checkbox"/>	DIAGNOSTIC MAMMOGRAM BILATERAL WITH ULTRASOUND IF NEEDED	G0204 77051 76642	<input type="checkbox"/>	WIRE LOCALIZATION BREAST MAMMOGRAPHIC GUIDANCE	19281	<input type="checkbox"/>		
<input type="checkbox"/>	DIAGNOSTIC MAMMOGRAM UNILATERAL WITH ULTRASOUND IF NEEDED	G0206 77051 76642	<input type="checkbox"/>	WIRE LOCALIZATION BREAST US GUIDANCE	19285	<input type="checkbox"/>		
<input type="checkbox"/>	DIAGNOSTIC MAMMOGRAM BILATERAL WITH TOMOSYNTHESIS AND ULTRASOUND IF NEEDED	G0204 G0279 77051 76642				<input type="checkbox"/>		
<input type="checkbox"/>	DIAGNOSTIC MAMMOGRAM UNILATERAL WITH TOMOSYNTHESIS AND ULTRASOUND IF NEEDED	G0206 G0279 77051 76642				<input type="checkbox"/>		
ULTRASOUND						<input type="checkbox"/>		
<input type="checkbox"/>	US BREAST LIMITED RIGHT	77642				<input type="checkbox"/>		
<input type="checkbox"/>	US BREAST LIMITED LEFT	76642				<input type="checkbox"/>		

Right Breast

Left Breast



** PLEASE NOTE LOCATION OF LUMP **

Fax this order to: (928) 532-1411

Scheduling Phone: (928) 537-6554

Radiology Dept Phone: (928) 537-6338



557 (11/16)

Acct# MR#
Adm: DOB:
Summit Healthcare Regional Medical Center

BREAST IMAGING ORDER FORM



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