Breast Imaging Request

CHICO
Breast Care
CENTER
A division of North State Radiology

1720 Esplanade
Chico, CA 95926
530 898-0502
FAX 898-0533
chicobreastcare.com

Patient Name: _____

Home Phone: _____ DOB: _____

Appointment Date: _____ TIme: _____

Prior Mammogram Location: _____

Date of Mammogram: _____

❑ Please call patient to schedule Exam

Please call our facility for assistance obtaining your prior images if they were not performed at Chico Breast Care Center or North State Imaging.

❑ Screening Mammogram:

Screening Mammogram to include Digital Breast Tomosynthesis, 2D Full Field breast imaging, and Computer Aided Detection (CAD). *Patient does NOT present with signs or symptoms of breast disease. May include dense breast issue.*

❑ Screening Breast Ultrasound:

Should ONLY be considered an adjunct to annual screening mammography in women with dense breast issue. May not be a covered benefit.

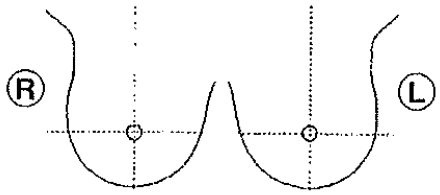
❑ Diagnostic Mammogram:

Diagnostic Mammogram to include Digital Breast Tomosynthesis, 2D Full Field breast imaging, and Computer Aided Detection (CAD). *To include diagnostic breast ultrasound when clinically indicated. Patient WITH signs or symptoms of breast disease, indicate area below:*

☐ Right ☐ Left ☐ Bilateral

☐ Palpable Mass
☐ Focal Pain
☐ Short-Term Follow-Up (<1 year)
☐ Nipple Discharge
☐ Skin or Nipple Change
☐ PT with history of breast CA

Date of Diagnosis: _____



Describe areas of concern:

_____
_____
_____
_____
_____

❑ Ancillary Breast Imaging Studies and Breast Biopsy:

☐ **Diagnostic Breast Ultrasound** only
☐ **MRI Breast**
☐ **MRI-Guided Breast Biopsy,** to include post-biopsy diagnostic unilateral mammogram and radiological surgical specimen.
☐ **Breast Biopsy,** to include post-biopsy diagnostic unilateral mammogram and radiological surgical specimen.
☐ **Needle localization of clip,** to include mammogram to assess wire placement.
☐ **Ductogram:** ☐ (Single duct) ☐ (Multiple ducts)
☐ **Needle Aspiration**

❑ DEXA Bone Density

Referring Provider Name (Please Print): _____

Referring Provider Signature: X _____ CC_____

Please FAX Form to: 530-898-0533 • Important patient information on back.