



CULLMAN REGIONAL

Women's Diagnostic Center

Outpatient Services
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Women's Diagnostic Center Order

Today's Date:

REPORTING INSTRUCTIONS

Routine

STAT Call Report - direct phone #: \_\_\_\_\_

after hours phone #: \_\_\_\_\_

pt to go pt to wait

STAT Fax Report - fax # \_\_\_\_\_

PATIENT LAST NAME (REQUIRED) FIRST M DATE OF BIRTH (REQUIRED) PATIENT DAYTIME PHONE
SYMPTOMS/DIAGNOSIS/HISTORY (REQUIRED) - INCLUDE ICD-10 CODE(S) IF KNOWN
INSURANCE PA# DATE OF LAST MAMMOGRAM
ORDERING PRACTITIONER (REQUIRED) PRACTITIONER SIGNATURE (REQUIRED - NO STAMPS)

Additional imaging/procedures may be done as determined by radiologist, if needed.
Call my office prior to doing additional studies.

IMAGING & PROCEDURES

SCREENING MAMMOGRAM (no breast symptoms or hx of cancer less 5 yrs)

With ABUS ultrasound if breast density is determined to be greater than 50%

3D SCREENING MAMMOGRAM (tomosynthesis)

DIAGNOSTIC MAMMOGRAM

3D DIAGNOSTIC (tomosynthesis)

DIAGNOSTIC ULTRASOUND, if indicated

ULTRASOUND BREAST(S) L R Bilateral

SCREENING ABUS ULTRASOUND FOR BREAST DENSITY ONLY

MRI BREASTS

IMAGE-GUIDED BREAST BIOPSY L R

Fine Needle Aspiration/cyst/fluid collection L R

Ok to biopsy if unsuccessful aspiration attempt

Bone Density

PATIENT SYMPTOMS/HISTORY (Other than diagnosis included above)

Blank lines for patient symptoms/history

ANY ADDITIONAL IMAGING PROCEDURES

Blank lines for additional imaging procedures

NEEDLE LOCALIZATION

RADIOLOGIST DISCRETION Right; position \_\_\_\_\_

MAMMOGRAPHY GUIDED Left; position \_\_\_\_\_

ULTRASOUND GUIDED

MRI GUIDED

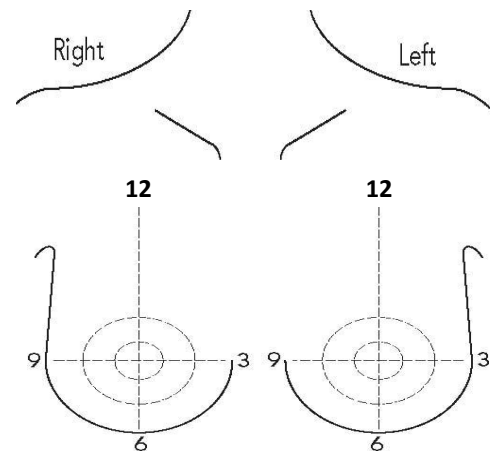
Diagnosis: \_\_\_\_\_

Special Instructions (ex: bracket or multiple sites)

\_\_\_\_\_

SCHEDULED SURGERY DATE \_\_\_\_\_ TIME \_\_\_\_\_

Sentinel Lymph Node



For Women's Center Office Use Only

Appointment Date/Time: \_\_\_\_\_ Patient notified on: \_\_\_\_\_

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures.