



## REFERRAL FOR BREAST IMAGING SERVICES

Patient Name: Jennifer Puryear

DOB: 9/13/1974

Referring Physician: Lindsey Burton, CNP  
(PRINT CLEARLY)

Office number: (334) 244-3281

Appointment Date/Time: to be scheduled by facility

☒ Screening Mammogram ☐ Bone Densitometry *Diagnosis:* \_\_\_\_\_  
No symptoms or clinical findings (☐ EMIC ☐ MBC ☐ PIC)

☐ Additional diagnostic studies (US, MRI) may be performed if indicated

☐ Diagnostic Mammogram

☐ Bilateral ☐ Unilateral ☐ Right ☐ Left

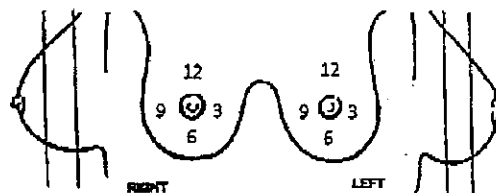
☐ Breast Ultrasound

☐ Bilateral ☐ Unilateral ☐ Right ☐ Left

☐ REQUIRED- Reason for exam

- ☐ Lump/mass/thickening
- ☐ Skin dimpling/nipple retraction
- ☐ Persistent focal pain/tenderness
- ☐ Nipple discharge
- ☐ Personal history of breast cancer
- ☐ Other \_\_\_\_\_

REQUIRED-Please mark location of area of concern



ICD10 Code Z12.31

☐ Special Procedures

- |                                                                             |                                |                               |
|-----------------------------------------------------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Needle biopsy (stereotactic, US guided, MR guided) | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Cyst Aspiration                                    | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Ductogram                                          | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Savi-Scout placement/Wire Localization             | <input type="checkbox"/> Right | <input type="checkbox"/> Left |

☐ Breast MRI Bilateral w/ & w/o contrast (☐ BMCE ☐ CIC ☐ EMIC ☐ PIC)

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

Prior mammogram at: \_\_\_\_\_

Please tell us any other pertinent details: \_\_\_\_\_

Referring Physician Signature: Lindsey Burton, CNP

DATE: 9/20/21

Time: 8:42