Women's Imaging Center

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Breast Imaging Requisition

Patients: Please bring this card with you to your scheduled appointment

Patient Name: _____

Date of Referral: _____/_____/_____ **Date of Birth:** _____/_____/_____

Phone Number: (_____) _____–_____ **Gender:** ☐ Female ☐ Male

INDICATE EXAM:

- ☐ **Screening Mammogram - 3D Digital Breast Tomosynthesis**
  (2D digital mammography available by request)
- ☐ **Diagnostic Mammogram and/or Ultrasound (as needed)**
  - ☐ Palpable Abnormality – Please Diagram Below
  - ☐ New Pain
  - ☐ Nipple Discharge
  - ☐ Other: _____
- ☐ **Breast Ultrasound**
- ☐ **Breast MRI**

Clinical History: _____

_____

Provider First/Last Name: _____

Provider Signature: _____

Location: