

Eyde Building, Ste 600 (6th Floor)
4660 S. Hagadorn Rd, East Lansing, MI 48823



Tax ID 83-2236308
NPI 1275165052

Patient Name _____ DOB _____ Phone _____

Diagnosis/ICD Code(s) _____

Reason for Test or Referral/Signs & Symptoms _____

Fax referral form with ins. card(s)—front & back (Molina Medicaid requires a non-par preauth #: _____)

Breast Imaging ¹

- Screening Mammogram
○ 3D
- Diagnostic Mammogram ²
○ 3D ○ Lt ○ Rt ○ Bilat
- Breast Ultrasound ^{3 4}
○ Lt ○ Rt ○ Bilateral
Location _____
- Galactogram
○ Lt ○ Rt ○ Bilateral
- Stereotactic Biopsy
○ Lt ○ Rt ○ Bilateral
- Ultrasound Guided Biopsy
Lt qty ____ Rt qty ____
- Cyst Aspiration
Lt qty ____ Rt qty ____
- Breast Consult/2nd Opinion

OB/GYN Imaging

- AFI
- Biophysical Profile
- Fetal Age (OB)
Weeks ____ ○ Twins
- Nuchal Translucency ⁵
Weeks ____ ○ Twins
- Pelvic

Bone Densitometry (DEXA)

Thyroid Imaging

Please refer to [General Radiology Referral Form](#)

Breast MRI

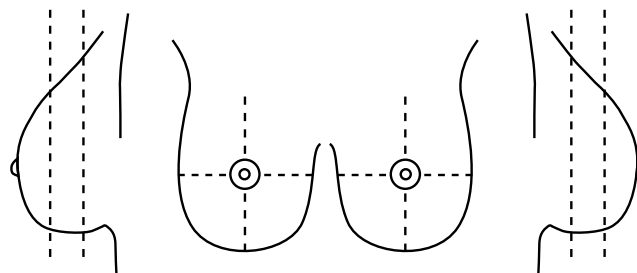
Please refer to [MR Referral Form](#)

Date of previous mammogram _____ Facility _____

Fam hx of breast ca/relation & age of dx _____

Pt hx of breast ca/age of dx ____ History of augmentation (implants)

Date of last Clinical Breast Exam (CBE) _____ (illustrate findings below)



PREPARATIONS

Breast Imaging

- Do NOT wear deodorant, powder, or lotion to your appointment.
- Bring ALL previous mammography/breast ultrasound images performed at other facilities to your appointment.

OB/GYN Imaging

- Drink 32 oz. of water 1 hour prior to exam time and hold bladder.

Biopsy/Aspiration

- Discontinue blood thinning and/or non-steroidal anti-inflammatory medications 7 days prior.

¹ Additional breast imaging and/or a biopsy may be performed if deemed necessary by the radiologist unless the following box is checked:

² For palpable lumps, ultrasound should also be scheduled.

³ If patient is under 30 years old, initial exam should be an ultrasound.

⁴ Diagnostic mammogram should be ordered for a new lump.

⁵ McLaren Medicaid requires preauthorization: _____

Referring Physician/Provider Information

Signature or stamp X _____

Print Name _____

Form filled out by _____

Office Phone _____

Office Fax _____