

# Breast Imaging Referral

## Mammography – Ultrasound



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

- Ambulatory
- Wheelchair/Walker
- Interpreter needed
- Prior UCSF mammograms
- Patient will bring outside studies.

### Referring Physician

Name: \_\_\_\_\_ Phone/Pager (required): \_\_\_\_\_

Attending (if different from referring provider): \_\_\_\_\_

Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

### Please select appropriate exam and check reason ordered:

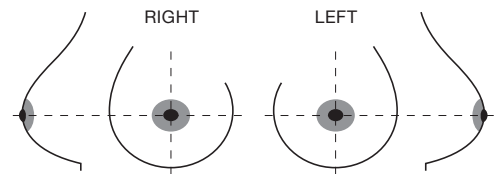
**Screening Mammography with Tomosynthesis (3D)**

- 2D mammography only     Patient has implants.

Additional diagnostic workup will be performed per SOP below.\*

- Please check here if you **DO NOT** want additional imaging without a new exam order.  
 Please check here if you **DO NOT** authorize a biopsy without a separate order.

Use diagram for diagnostic exams only.



**Diagnostic Breast Imaging (Tomosynthesis Mammography)**

A radiologist-monitored exam for symptomatic patients, those recalled from screening, post breast conservation treatment for cancer and radiologist-requested follow-up exams. Includes all mammograms needed for complete evaluation. Ultrasound, if indicated, may incur an additional charge.

- Bilateral**     RIGHT     LEFT
- Breast Lump or Mass**     RIGHT     LEFT  
(indicate \_\_\_\_\_ o'clock position and distance \_\_\_\_\_ cm from nipple)
- Focal Breast Pain**     RIGHT     LEFT  
(indicate \_\_\_\_\_ o'clock position and distance \_\_\_\_\_ cm from nipple)
- Personal History of Breast Cancer** (lumpectomy within past five years)
- Abnormal Prior Mammogram** (radiologist-requested follow-up)

- Nipple Discharge: bloody or clear**  
Imaging is indicated only if discharge is spontaneous (occurs without squeezing) and is either bloody or clear.

- Breast Calcifications**
- Other** (specify): \_\_\_\_\_  
\_\_\_\_\_

**Targeted Ultrasound** (patients under 30, pregnant patients)     RIGHT     LEFT

A specific area of clinical concern must be indicated. \_\_\_\_\_ o'clock position and distance \_\_\_\_\_ cm from nipple

### Other Imaging Services

(ICD-10 codes and insurance authorization required)

	BILATERAL	RIGHT	LEFT
<input type="checkbox"/> <b>Ultrasound Guided Core Biopsy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Ultrasound Guided Cyst Aspiration</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Stereotactic Biopsy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Additional Clinical Information

(include special instructions/precautions)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Berkeley Outpatient Center**  
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 Berkeley, CA 94702  
**Imaging Clinic:** (510) 985-5030  
**Scheduling:** (415) 353-3900  
**Fax:** (415) 353-7299

\*Breast Imaging Standard Operating Procedure (SOP) will be followed if any additional imaging or biopsy is necessary. This SOP pertains to a radiologist-monitored exam for symptomatic patients, those recalled from screening, post breast conservation treatment for cancer, and radiologist-requested follow-up exams. It also includes all mammograms needed for complete evaluation. Ultrasound, if indicated, is an additional charge. The patient receives results at the time of exam for callbacks from screening, diagnostic mammogram and ultrasound.