MSU Health Care at McLaren GREATER LANSING | Breast Imaging Center

REFERRAL FORM

3520 Forest Road, 3rd Floor
Lansing, MI 48910
mclaren.org/lansing

Clinic: 517-975-6425
Fax: 517-975-2909
TIN: 38-1434090

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
- ☐ Pelvic
- ☐ **Bone Densitometry (DEXA)**

Thyroid Imaging

Please refer to ***General Radiology Referral Form***

Breast MRI

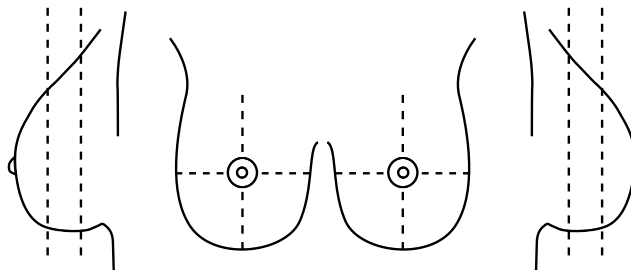
Please refer to ***MR Referral Form***

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.*

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.*

Referring Physician/Provider Information

Signature or stamp X ______________________________

Print Name ______________________________

Form filled out by ______________

Office Phone ______________

Office Fax ______________