NEWTON-WELLESLEY HOSPITAL

Centralized Scheduling Department
(617) 243-6800 FAX (617) 243-6776
FAX (617) 243-6594

WOMEN'S IMAGING CENTER

WRITTEN ORDERS

	INSURANCE REFERRAL NO. (If Known)	
PATIENT NAME	D.O.B.	TEST SCHEDULED ON
MRN#	Date:	
Physician's Name	Physician's Phone	
Physician's Pager	Physician's Fax	

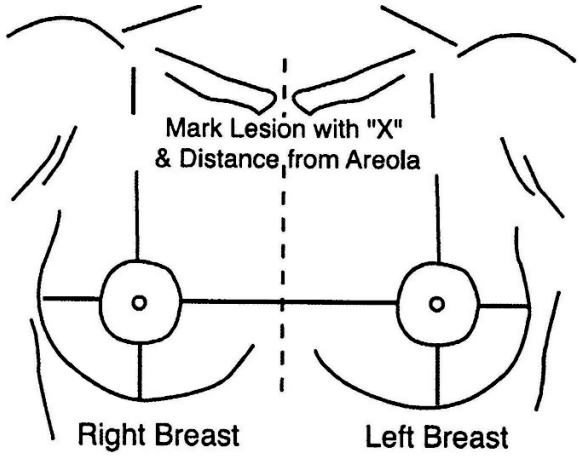
Asymptomatic Screening

❒ Mammogram

or

Diagnostic Evaluation

❒ Mammogram
❒ Breast Ultrasound
❒ Mammogram and Breast Ultrasound



Reason for Diagnostic Exam:

	Rt.	Lt.
❒ Palpable Mass / Thickening	❒	❒
❒ Discharge	❒	❒
❒ Pain (Focal)	❒	❒
❒ Other High Risk Biopsy	❒	❒
❒ Previous Mastectomy	❒	❒
❒ Personal Hx Breast Ca	❒	❒
❒ Follow-up / Advised by Radiology	❒	❒

Other Pertinent History or Findings

_____
_____
_____
_____

Mass

Rt.	Lt.
❒ Hard	❒
❒ Soft	❒
❒ Cystic	❒

❒ Biopsy if Needed

Physician's Signature _____