Patient Name: ___________________________ Ordering Provider: __________________________ NPI #: __________
VCU Health MRN (VCU use only): ________________ Ordering Provider Signature: __________________________
Patient Phone Number: ______________________ Ordering Provider Phone Number: __________________________

☐ VCU Health – Breast Imaging – Stony Point
9000 Stony Point Parkway – 2nd Floor
Richmond, Virginia 23235

☐ VCU Health – Breast Imaging – Downtown Campus
Nelson Clinic Building – 3rd Floor, Rm 300
401 North 11th Street, Richmond, Virginia 23298

☐ Screening Mammogram (Z12.31)
☐ No current breast concerns
☐ Personal history of surgery for breast cancer > 1 year ago
☐ Family history of breast cancer (Z80.3) (specify): __________________________

IMPORTANT: Please select statement to proceed with additional imaging, as needed
☐ “I agree to diagnostic mammography, breast-axilla ultrasound, aspiration/biopsy, pathology, ductography and/or breast MRI as deemed medically indicated by the radiologist.”

☐ Diagnostic Mammogram _______ Right _______ Left _______ Bilateral
Mark the indications for diagnostic study:
☐ Palpable lump(s) (N63) Indicate location(s) below on diagram
☐ Palpable breast thickening / induration of breast (N64.51) Indicate location(s) below on diagram
☐ Nipple discharge (N64.52) _______ Right _______ Left
☐ Retraction of nipple (N64.53) _______ Right _______ Left
☐ Breast pain (focal) (N64.4) Indicate location(s) below on diagram
☐ Personal history of breast cancer (Z85.3) Date of diagnosis: ______________
☐ Follow-up of previous mammographic or sonographic abnormality (R92.8)
☐ OR known breast cancer: (enter ICD-10 code for specific breast cancer): __________________________
☐ Pre-surgical or post-neoadjuvant treatment
☐ Other signs & symptoms in breast (Z64.59) (please specify): __________________________

☐ Diagnostic Breast Ultrasound _______ Right _______ Left _______ Bilateral

☐ Breast MRI Indication: __________________________
☐ Procedure _______ Cyst aspiration _______ Core needle biopsy _______ Ductogram (galactogram)
 _______ Right _______ Left _______ Bilateral

Exam and Pertinent Information
Date of Last Breast Exam: ______________
☐ Normal
☐ Abnormal __________________________

Medical Records Copy