**Prescription Form**

##### Please bring this form with you to your appointment

Name DOB

**Patient Information:**

Work or Cell Phone Evening or Home Phone Height Weight

Insurance

Subscriber :

ID# Group #

Referring Clinician: **Reason for Study**

Appt. Date Appt. Time

##### Note: Please insure that when getting authorization for the Breast MRI, the provider is listed as Washington Imaging Services.

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| --- | --- |
| Exam & Indication Please Check |  |
|  *MRI Breast w/contrast & MRI Chest w/o contrast*O Recent diagnosis of breast cancer ‐ stagingO Malignant lymph node with no known primary tumor andnegative mammogramO Pre‐ or Post‐Neoadjuvant chemotherapyO Post‐operative evaluation: (+) margins ‐ assess for residual tumorO History of breast cancer ‐ assess for recurrence *MRI Breast w/contrast*O Inconclusive mammogram and/or ultrasound (suspicious findings)O Annual Breast MRI screening per ACS guidelines(after mammogram):* Breast Cancer gene (BRCA 1or 2) mutation carriers ‐ serum positive.
* First‐degree relative of BRCA gene mutation carrier, but untested
* Lifetime risk of 20‐25% or greater, as defined by BRCAPRO statistical model
* Radiation to chest between age 10 and 30 years
* *MRI Guided Breast Biopsy* O *Right* O *Left*
* *MRI Guided wire localization* O *Right* O *Left*
* *MRI Breast w/contrast with Implant Evaluation*

O Implants and suspected cancer (2) separate appointments* *MRI Breast w/out contrast with Implant Evaluation*

O Implants ‐ suspect rupture, no suspicion of cancer |

|  |  |
| --- | --- |
| Important Clinical Information |  |
| * *Fax clinical notes on patient history and breast physical ex‐ amination (*ex. Mammo reports, Breast US reports.)
* *Fax clinical breast biopsy pathology results*

O Breast surgery history:Breast Cancer gene (BRCA 1or 2) mutation carriers ‐ serum positive.* + Date of surgery
	+ Surgeon:
	+ Fax pathology reports

O Breast biopsy history:* + Stereotactic  Ultrasound Dates:
* *History of radiation therapy?* O Yes O No

O When completed? * *Date of last menstrual cycle:*

*(Exams scheduled between day 7 and 13 of cycle)*O On BCP? O Yes O NoO Lactating? O Yes O No* *Previous mammograms/ultrasound exams:*

O When? Performed where? O When? Performed where? O Have mammogram/ultrasound CD’s and reports been requested? Yes  NoO Being sent to us?  Yes  No |

**Other Notes & Requests:**

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**REFERRING PRACTITIONER SIGNATURE (Required for Exam)**

 **Name** **Signatur**