

# Referral for Evaluation and Treatment

Referred by\*

Patient DOB\*

Today's Date\*

Patient Name\*

Patient Phone Number\*

## Orders:

### CONSULTATIONS

- Breast Health Visit with Imaging Orders
- Breast Imaging Expert 2nd Opinion
- Surgical/Procedural Consultation

### IMAGING - SCREENING

- Screening Ultrasound
- Screening Mammogram

### LATERALITY (check one):

- Left
- Right
- Bilateral

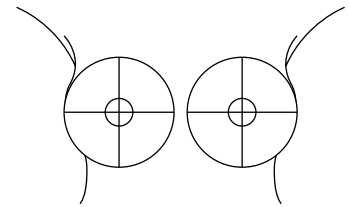
If applicable, mark the quadrant(s) where symptoms occur:

### BIOPSIES

- Ultrasound-Guided Biopsy
- Stereotactic Biopsy
- Vera Breast CT Biopsy

### IMAGING - DIAGNOSTIC

- Diagnostic Ultrasound
- Diagnostic Mammogram
- Contrast Enhanced Mammogram
- Vera Scan Breast CT with Contrast



## Indications:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Palpable Lump/Thickening/Swelling†     | <input type="checkbox"/> Skin Dimpling/Peau d'Orange†      | <input type="checkbox"/> High Risk - Density (C or D)  |
| <input type="checkbox"/> Pain - Diffuse/Bilateral               | <input type="checkbox"/> Breast or Nipple Infection        | <input type="checkbox"/> High Risk - Tyrer-Cuzick ≥20% |
| <input type="checkbox"/> Pain - Focal/Specific Area†            | <input type="checkbox"/> Implant Issues†                   | <input type="checkbox"/> High Risk - Genetic Mutation  |
| <input type="checkbox"/> Nipple Discharge - Milky/Green         | <input type="checkbox"/> Prior Findings on Imaging         | <input type="checkbox"/> Intolerance to Compression    |
| <input type="checkbox"/> Nipple Discharge - Bloody/Clear†       | <input type="checkbox"/> Personal History of Breast Cancer | <input type="checkbox"/> Intolerance to MRI            |
| <input type="checkbox"/> Nipple Changes - Inversion/Rash/Crust† | <input type="checkbox"/> Surgical Clearance                | <input type="checkbox"/> Other: _____                  |

## Requesting:

- First Available
- Breast Radiologist
- Leslie Memsic, MD, FACS
- Heather Richardson, MD, FACS
- Bri Grantham, NP-C, Breast Health Specialist
- Natalie Rabb, NP-C, Breast Oncology Navigator

Physician's Signature

Physician's Notes

436 N Bedford Drive, Suite 308 | Beverly Hills, CA 90210 | BedfordBreastCenter.com

Patient: Call 310.278.8590 to schedule appointment | Referring Physician: Fax to 424.202.3759

Please bring this form with you to your appointment.

\*Required fields | †Order both diagnostic mammogram and diagnostic ultrasound