MICHIGAN STATE UNIVERSITY HEALTHTEAM
Women's Imaging Center

Eyde Building, Ste 600 (6th Floor)
4660 S. Hagadorn Rd, East Lansing, MI 48823

Women's Imaging Referral Form

Ph 517-353-4920 (Ext 2)
Fax 517-884-0000
www.rad.msu.edu

Tax ID 386005984
NPI 1891747614

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
- ☐ Nuchal Translucency [5]
  - Weeks _____ ○ Twins
- ☐ Pelvic
- ☐ **Bone Densitometry (DEXA)**

Thyroid Imaging

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

Breast MRI

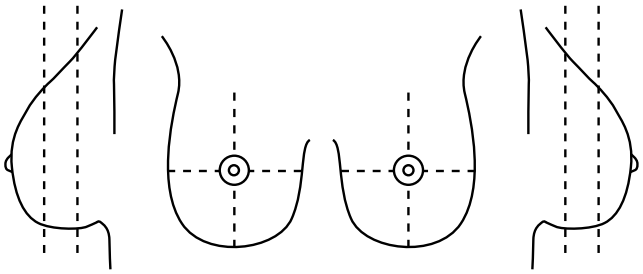
*Please refer to **MR Referral Form***

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.*

OB/GYN Imaging

- *Drink 32 oz. of water 1 hour prior to exam time and hold bladder.*

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.*

5 *McLaren Medicaid requires preauthorization:* _____

Referring Physician/Provider Information

Signature or stamp X _____

Print Name _____

Form filled out by _____

Office Phone _____

Office Fax _____

Print, Sign & Fax END OF FORM