

# CRG Mammo/Breast Order Form



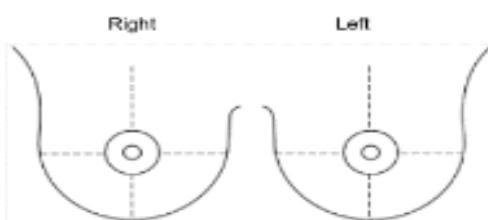
CHEYENNE WOMEN'S IMAGING PAVILION

To Schedule an Appointment Phone: 307-634-7711 or Fax: 307-634-7760

Patient Name:		DOB:	Weight:	Date of Request:
Patient Address:		Phone:		
Insurance:	Policy #:			Payer ID:
ICD 10 Codes:				

Previous Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> US/Mammo add'l imaging of breast if indicated by Radiologist <input type="checkbox"/> Order ok to be altered by Radiologist		
If yes, where/when _____				
<b>SCREENING MAMMOGRAM</b>		<b>CPT</b>	<b>ULTRASOUND BREAST</b>	
Bilateral Screening 3D/Tomo Mammo		77063	<input type="checkbox"/> US Breast limited R _____ L _____ <input type="checkbox"/> US Bilateral Breast Complete (dense breasts)	
Bilateral Screening Mammo 2D only		77067	<b>CPT</b>	
<b>DIAGNOSTIC MAMMOGRAM</b>		<b>CPT</b>	<input type="checkbox"/> *Female patients <30 years symptomatic US first. <input type="checkbox"/> *Female patients >30 years symptomatic must have recent Mammo. <input type="checkbox"/> *Male patients <20 years symptomatic US first. <input type="checkbox"/> *Male patients >20 years symptomatic Mammo first then US.	
Bilateral Diagnostic Tomo Mammo		77062		
Right Diagnostic Tomo Mammo R _____ L _____		77061		
Bilateral Diagnostic Mammo 2D only R _____ L _____		77066		
Unilateral Diag Mammo 2D only R _____ L _____		77065		
<b>DIAGNOSTIC REASONING:</b>				
<input type="checkbox"/> Add'l Views/Abn mammogram R _____ L _____ <input type="checkbox"/> History of breast Cancer R _____ L _____ <input type="checkbox"/> Palpable lump or mass R _____ L _____ <input type="checkbox"/> Breast Pain or Tenderness R _____ L _____ <input type="checkbox"/> Nipple Discharge/Discoloration R _____ L _____ <input type="checkbox"/> Short term follow-up R _____ L _____ <input type="checkbox"/> Skin Dimpling or Thickening R _____ L _____ <input type="checkbox"/> Other: _____				
<b>BREAST PROCEDURES</b> <input type="checkbox"/> MG Stereotactic biopsy 1st lesion R _____ L _____ 19081 <input type="checkbox"/> MG stereotactic biopsy additional lesions R _____ L _____ 19082 <input type="checkbox"/> Placement of breast localization device R _____ L _____ 19281 <input type="checkbox"/> Placement of add'l breast localization device R _____ L _____ 19282 <input type="checkbox"/> Galactogram single duct R _____ L _____ 77053 <input type="checkbox"/> Galactogram add'l ducts R _____ L _____ 77054 <input type="checkbox"/> US Guided Breast Biopsy R _____ L _____ 19083 <input type="checkbox"/> US Breast placement of localization device R _____ L _____ 19285 <input type="checkbox"/> US Guided Breast cyst aspiration R _____ L _____ 19000 <input type="checkbox"/> US Breast/Axilla Lymph Node Biopsy R _____ L _____ 38505 <i>staging BR CA</i> <input type="checkbox"/> MRI Guided Biopsy, Aspiration, or Injection Localization 77021 <input type="checkbox"/> MRI Guided Breast Biopsy R _____ L _____ 19085				

MARK AREAS OF CONCERN: (NEW symptoms only)



Additional Comments:

Special Care Instructions:

- Cane/Walker
- Wheelchair
- Breast Implants

Implant type: \_\_\_\_\_

Facility Name, Address, phone number and fax:

Provider Signature: \_\_\_\_\_

Printed Provider Name and NPI Number: \_\_\_\_\_