BREAST MRI ORDERS Scheduling: 537-7171 Fax: 537-7809 MRI Department: 537-7500 Fax: 537-7812

THE QUEEN'S MEDICAL CENTER QMC Contact: ______________________
HONOLULU, HAWAII NAME / DEPT.

OUTPATIENT TESTING ORDERS

☐ Contact patient directly to schedule an appointment.

FOR PHYSICIAN OFFICE USE ONLY: Schedule test/procedure by calling the appropriate department. Include reason for testing (specific signs and symptoms. NOT "rule out" or "routine" diagnosis) and physician's signature and dated prior to or on the date of service.

PATIENT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF SERVICE

PATIENT INSURANCE (PRIMARY)	PATIENT INSURANCE (SECONDARY)	CONTACT PHONE	OTHER PHONE

TEST/SERVICE/PROCEDURE: ______________________
(Include frequency/duration if more than one visit date to above)

CPT Code(s) ______________________

DIAGNOSTIC/INDICATION: ______________________
("Rule out" or "routine" not acceptable to above)

ICD9 Code(s) ______________________

HISTORY OR RISK: ______________________
(Include personal or family medical history to above)

SYMPTOMS/COMPLAINTS: ______________________

The above test is medically necessary:
ORDERING PHYSICIAN'S SIGNATURE: ______________________ Date ________

Print MD Name/Stamp: ______________________

PHYSICIAN'S OFFICE PHONE	PHYSICIAN'S OFFICE FAX

Copies to: ______________________

☐ Pt to Return w/CD

Special Instructions: ______________________

This must be completed to schedule MRI Testing

Drug Allergies	________	Pregnant	Yes ____ No ____	Hx of metal in eyes	Yes ____ No ____
Claustrophobic	Yes ____ No ____	Heart Surgery	Yes ____ No ____	Sheet metal	Yes ____ No ____
Brain surgery	Yes ____ No ____	**Pacemaker**	Yes ____ No ____	(welder, machinist, etc.)	
Aneurysm clips	Yes ____ No ____	**Any type of metallic implant:**	Yes ____ Item: ____________		No ____
Patient Weight	________ lbs.	Renal disease	Yes ____ No ____		

Last Mammogram ____ **Queen's Medical Center** ____ **Other facility** ______________ **Date** ________

Patient History

Is patient still menstruating? ____ Y ____ N Date of LMP ____________

If no, ____ Menopause ____ Hysterectomy Does patient still have ovaries? ____ Y ____ N

Patient History of Breast Cancer? ____ Y ____ N Date of Diagnosis ____________

Family History of Breast Cancer ____ Mother ____ Sister ____ Daughter Age at Diagnosis ________

____ Grandmother ____ Aunt ____ Niece Age at Diagnosis ________

REASON FOR BREAST MRI EXAM

____ Pre surgical evaluation

____ Recently diagnosed breast cancer ____ Left ____ Right

____ Neo-Adjustment Chemotherapy How many cycles? ________ Date of first cycle ____________

____ High Risk Screening

____ genetic predisposition (BRCA+)

Has risk assessment been done? ____ Y ____ N By Whom? ____________

Percentage of risk ____ 5 year risk ____ Lifetime risk ________ %

____ Post-op Date of Surgery ____________

Pathology Diagnosis ____ DCIS ____ IDCA ____ ILCA ____ ADH ____ LCIS

____ Rule out implant rupture ____ silicone ____ saline

____ Other ______________________