

Physician Exam Request Form



Lake Charles Memorial Health System
BREAST HEALTH

Patient Name: _____

DOB: _____ Phone: _____

Appointment Date: _____ Appt. Time: _____

☐ Implants ☐ Saline ☐ Silicone ☐ No Implants

☐ Bilateral ☐ Unilateral ☐ Left ☐ Right

MAMMOGRAPHY - there must be a diagnosis for every test requested:

☐ SCREENING MAMMOGRAM

☐ Routine - no problem (Z12.31)

☐ Routine - personal history of breast cancer (Z12.31)

☐ BREAST ULTRASOUND

☐ Additional mammography images and/or breast ultrasound for abnormal screening mammogram (R92.8) (if indicated) ☐ Left ☐ Right ☐ Bilateral

☐ Breast Biopsy (if indicated)

☐ DIAGNOSTIC MAMMOGRAM

☐ Pain (N64.4)

☐ Breast cancer (C50.919)

☐ Cyst (N60.09)

☐ Fibrocystic breast (N60.19)

☐ Lump/nodule (N63)

☐ Discharge (N64.52)

☐ Calcifications (R92.1)

☐ Abnormal mammogram (R92.8)

☐ BONE DENSITY

☐ Osteoporosis (M81.0)

☐ Osteopenia (M85.80)

☐ Post menopause (M81.0)

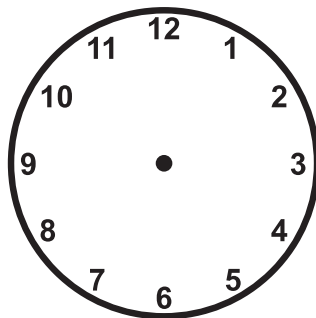
☐ Hormone deficiency (E34.9)

☐ Other

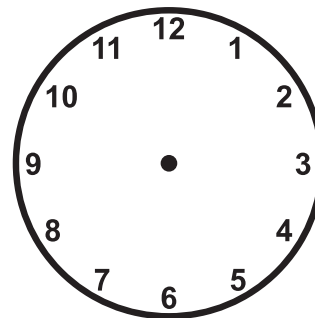
☐ Screening (Z13.820)

COMMENTS:

Indicate Area of Concern



RIGHT



LEFT

Please schedule at the following location:

- ☐ Memorial Hospital - 701 Oak Park Boulevard, Lake Charles, LA 70601 | 337.494.4755
☐ Memorial Hospital for Women - 1900 Gauthier Road, Lake Charles, LA 70605 | 337.480.7444
☐ Moss Bluff Diagnostic Center - 217 Sam Houston Pkwy., Ste. 102, Lake Charles, LA 70611 | 337.494.3070
☐ First location available

To schedule, fax form to 337.494.6524 or email to radiologyorders@lcmh.com

Date: _____ Physician Signature: _____

cc results to: _____