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)
☐ Post menopause (M81.0)
☐ Other

☐ Osteopenia (M85.80)
☐ Hormone deficiency (E34.9)
☐ Screening (Z13.820)

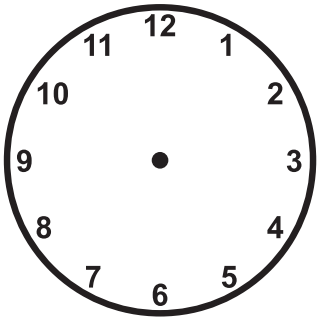
COMMENTS:

_____

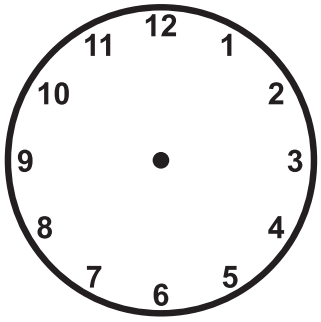
_____

_____

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:_____