Mammography Protocol Order

Patient's name: ______________________________ Date of birth: ____________________

Asymptomatic

Screening mammogram with tomo	Bilateral	RT	LT
Screening mammogram 2-D (only)	Bilateral	RT	LT
Breast MRI (high-risk screening)	Bilateral		

Symptomatic

Diagnostic mammogram with tomo	Bilateral	RT	LT
Diagnostic mammogram 2-D (only)	Bilateral	RT	LT
Breast ultrasound	Bilateral	RT	LT
Axilla ultrasound	Bilateral	RT	LT
Breast MRI	Bilateral		
Breast MRI implant integrity (no contrast)	Bilateral		

Reason for exam/indication: ______________________________

Location/area of interest: ______________________________

Follow Norton Healthcare mammography protocol	**YES**	**NO**
If indicated, refer patient to high-risk breast services	**YES**	**NO**

Procedures

Stereotactic biopsy	Bilateral	RT	LT
Ultrasound-guided breast biopsy	Bilateral	RT	LT
Axilla ultrasound-guided biopsy	Bilateral	RT	LT
Needle localization	Bilateral	RT	LT
Breast aspiration	Bilateral	RT	LT

Fax orders to **(502) 394-3636**

Centralized Scheduling: (502) 485-4700

Signature: ______________________________ Date: ____________________

To print more mammography protocol order forms, visit **NortonHealthcareProvider.com** and click on the "Forms" tab.

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