Bellevue Women's Imaging, PLLC

Office Hours: M-F 7am-7pm

1400 116th Ave NE Bellevue, WA 98004
Phone 425-454-1700 Fax 425-454-0600 www.bmirad.com

See exam preparations, map and directions on back.

PLEASE FAX TO: (425) 454-0600

Patient Name_____ **DOB** _____/_____/_____

Phone Number(s) (____)_____ **Insurance/Auth #**_____

Referring Physician _____ **Phone (____)** _____ **Fax (____)** _____

Signature _____ **Date** _____/_____/_____

□ **BWI to call patient to schedule** □ **Referring Office to call patient to schedule**

Report delivery: □ **Routine** □ **Stat** □ **Send CD w/ Pt.** □ **Send CD to Office**

Clinical Signs or symptoms (required) – ICD-9 codes are helpful _____

_____

Contrast Allergies □Yes □ No **Pregnant** □Yes □ No **Breast Feeding** □Yes □ No

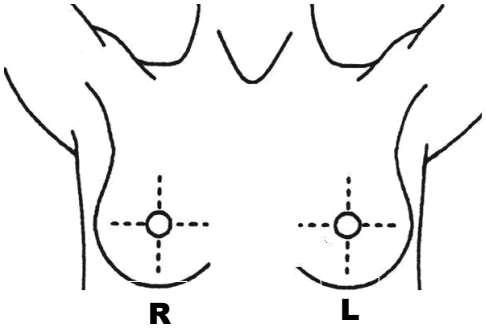
APPOINTMENT DATE:_____**TIME:**_____

□ **Screening Mammogram -** upgrade to Diagnostic Mammogram if indicated
□ **Screening Mammogram with Ultrasound** if indicated
□ **Screening Mammogram only -** referring office to be called prior to further imaging
□ **Diagnostic Mammogram -** with Ultrasound, Biopsy or Galactogram if indicated

□ **Palpable lump / duration** → **R L** _____
□ **Thickening / duration** → **R L** _____
□ **Pain / tenderness** → **R L** _____
□ **Nipple discharge** → **R L** _____
□ **Nipple inversion** → **R L** _____
□ **Prior breast cancer** → **R L Year:**_____
□ **Follow-up imaging abnormality**
□ **Implant Evaluation**

Notes: _____

Please mark area of concern:



□ **Ultrasound** □ Breast □ Abdomen* □ Pelvis* □ OB* □ Other_____
□ **MRI** □ Breast* □ Pelvis* □ Other _____
□ **Breast Biopsy*** guided by: □ US □ MR □ Stereotactic
□ **DEXA***
□ **Hysterosalpingogram*** □ **Hysterosonogram***
□ **Other Exam** □ CT* □ Fluoro* □ Plain Film □ Other_____

PLEASE SPECIFY PRIOR RELEVANT IMAGING STUDIES—THIS IS VERY HELPFUL.
Study _____ **Facility** _____ **Exam date**_____
Study _____ **Facility** _____ **Exam date**_____

*** *Exam requires a prep. See reverse side.***