ST. MARY'S HEALTH CARE SYSTEM
A Member of Trinity Health

# OUTPATIENT ORDER FORM
# WOMEN'S HEALTH

Appt. Date: _____

Appt. Time: _____

Arrival Time: _____

☐ MAIN HOSPITAL
1230 Baxter St., Athens, GA

☐ OUTPATIENT DIAGNOSTIC CENTER
2470 Daniells Bridge Rd., Athens, GA

TO SCHEDULE: 706.389.2700
FAX this order and required clinical records to: 706.389.2711

| PATIENT'S LEGAL NAME | DATE OF BIRTH | PATIENT PHONE | INSURANCE COMPANY NAME |
|---|---|---|---|
| | | | |

**PHYSICIAN OFFICES** Tests cannot be performed without listing the signs/symptoms and/or reason(s) for each test ordered along with the ICD-10 code. Federal law requires that we inform you when ordering tests that will be paid under federal health programs, including Medicare and Medicaid, physicians should only order tests that are medically necessary for diagnosis or treatment of the patient, not for screening purposes.

***Your office will be contacted prior to test being performed if form is not complete.***

| PATIENT SIGNS/SYMPTOMS | ICD-10 CODE: |
|---|---|
| | |

PHYSICIAN NAME (PLEASE PRINT)

X _____ _____
ORDERING PHYSICIAN'S SIGNATURE — DATE/TIME
*Signature Stamps Are Not Valid*

❑ CALL REPORT TO _____

❑ FAX REPORT TO _____

SPECIAL INSTRUCTIONS

## MAIN HOSPITAL LOCATION

### DIGITAL SCREENING MAMMOGRAM

___ RIGHT ___ LEFT ___ BILATERAL

*___ Proceed with additional work-up to include biopsy as recommended by radiologist.

### DIGITAL DIAGNOSTIC MAMMOGRAPHY *(may include ultrasound, as needed)*

___ RIGHT ___ LEFT ___ BILATERAL

*___ Proceed with additional work-up to include biopsy as recommended by radiologist.

*Select the following indications:*

___ FOLLOW-UP TO ABNORMAL MAMMOGRAM

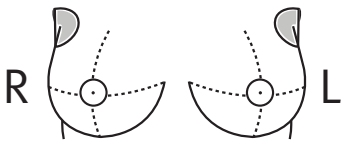
___ PERSONAL HISTORY OF BREAST CANCER *Diagnosis date* _____

___ PAIN IN A SPECIFIC AREA OF THE BREAST

___ PALPABLE MASS/LUMP

___ SKIN CHANGES

___ NIPPLE DISCHARGE



*indicate area(s) of concern*

### BREAST ULTRASOUND

___ RIGHT ___ LEFT ___ BILATERAL

### BREAST MRI

___ RIGHT ___ LEFT ___ BILATERAL

___ WITHOUT CONTRAST – **implants**

___ WITH CONTRAST – **evaluation for breast cancer**

## MAIN HOSPITAL LOCATION

### INTERVENTIONAL/DIAGNOSTIC PROCEDURES

___ ULTRASOUND GUIDED BIOPSY
___ CYST ASPIRATION
___ NEEDLE LOCALIZATION
___ GALACTOGRAM
___ MRI GUIDED BIOPSY
___ STEREOTACTIC BIOPSY
___ CONSULT/SECOND OPINION

## OUTPATIENT DIAGNOSTIC & WELLNESS CENTER

### DIGITAL SCREENING MAMMOGRAM

___ RIGHT ___ LEFT ___ BILATERAL

*___ Proceed with additional work-up to include biopsy as recommended by radiologist.

### BONE DENSITY SCAN

___ BONE DENSITOMETRY (DEXA)

### PATIENT INSTRUCTIONS

- Patient should wear a two-piece outfit.
- Do NOT use deodorant, perfumes, powders, ointments, or anything in the underarm area or breasts until the exam is completed.
- Please bring previous mammography films with you on the date of your appointment if not performed at St. Mary's. This will allow us to provide your results more quickly.

ST. MARY'S®
HEALTH CARE SYSTEM
A Member of Trinity Health

For information call **706-389-3000** or **1-800-233-STMH**
or visit our website at **stmarysathens.org**