NEWTON-WELLESLEY HOSPITAL

Date _____

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

MRI Breast Requisition

❒ **CD Requested** ❒ **CD with patient**
❒ **Report and images on web server request secure access**

MRI scheduling: CALL: 617-243-6217
FAX: 617-243-5563

Required Information:

Patient Name _____ Date of Birth |__|__|__|__|__|__|__|__|

Home Phone _____ Authorization # _____

Billing Information: ❒ Health ❒ MVA ❒ W/C ❒ Other _____ Medical Record # |__|__|__|__|__|__|__|__|

Insurance Carrier _____ Policy # _____

Physician Name _____ Phone _____

Clinical History (ICD-Diagnosis Code) _____

❒ Post-menopausal ❒ Peri-menopausal LMP_____ ❒ Pre-menopausal LMP_____
(Screening Breast MR should be performed in the second week of the menstrual cycle)

Signs/Symptoms:

❒ **Known Breast CA**
❒ **Known Breast CA, assess the response to chemotherapy**
❒ **Known BRCA1 or BRCA2 mutation**
❒ **Family history of Breast CA**
❒ **Personal history of Breast CA**
❒ **Family history of Ovarian CA**
❒ **Abnormal Mammogram or ultrasound**
  ❒ **Evaluate suspicious clinical finding which is not clearly defined or localized after mammography and ultrasound**
❒ **Rupture of implants**
❒ **Hx of abnormal histology on biopsy**
❒ **Follow up of previous abnormal MRI**
❒ **Radiation Therapy to chest when aged less than 30 years**
❒ **Other** _____

EXAM TYPE *(Please check)*

❒ **Bilateral Breast MRI with and without Contrast and CAD**
❒ **Other** _____
(Please Specify)

This order includes authorization to perform an orbital x-ray and serum creatinine, if necessary based on patient history.

Appointment Date / Time _____

MD Signature: _____ Date: _____