CLEAR CHOICE IMAGING

## REQUEST FOR MAMMOGRAPHY/BONE DENSITY SERVICES

Patients Name: _____ DOB: _____

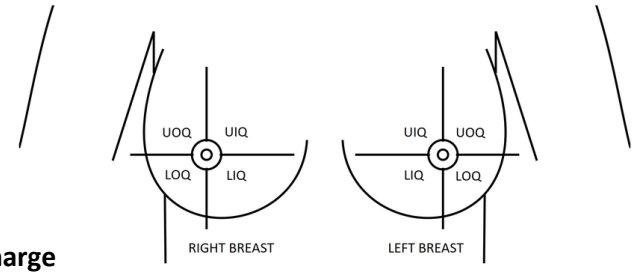
Cell Phone: _____ Home Phone: _____

☐ **Screening mammogram**

☐ **Diagnostic mammogram**
☐ Bilateral ☐ Left ☐ Right

☐ **Breast Ultrasound**
☐ Bilateral ☐ Left ☐ Right

☐ **Lump** ☐ **Pain** ☐ **Skin Changes** ☐ **Nipple discharge**
(Use diagram to mark location)




☐ **Breast Biopsy**
☐ Ultrasound ☐ Stereotactic

☐ **Bone Density**

**Clinical Indication/ICD-10 Code:** _____

**Frisco**
9990 Dallas Pkwy
Ste 110
Frisco, TX 75033
P: 469-887-4624
F: 469-782-3795

**PLEASE ADVISE YOUR PATIENT OF THE FOLLOWING:**

- Prior breast imaging must be brought in at the time of the appointment for comparison
- Reframe from wearing deodorant, and/or powder to appointments
- Small children MUST be attended by an adult while patient is receiving diagnostic services
- Please bring photo ID and insurance cards for check-in process

[X] With additional images, and/or Breast Ultrasound as needed, for abnormal Screening mammogram, as recommended by radiologist

Physician Name (Printed): _____ Physician Signature (REQUIRED): _____

Office Phone: _____ Office Fax: _____

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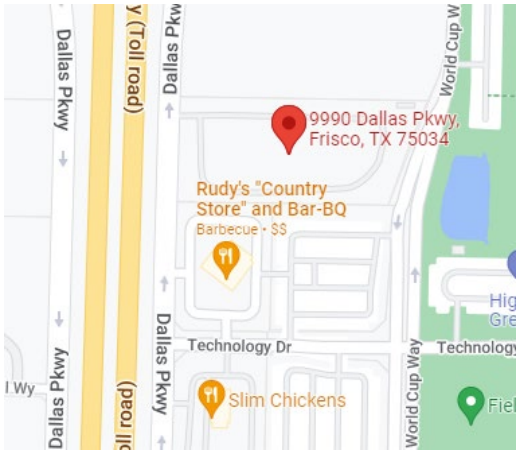
**Frisco**
9990 Dallas Parkway Suite 110
Frisco, TX 75033

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