HSHS St. Anthony's Memorial Hospital

RADIOLOGY WOMEN'S HEALTH ORDERS

Scheduling Phone #: 217-347-1540

SCHEDULED DATE & TIME: Pre-Authorization # _____

Diagnosis / Indications: ◆ (Required for billing / Reimbursement)

1. _____
2. _____
3. _____

Any test for screening? ❑ Yes ❑ No

Please list: _____

_____

Name: _____

Date of Birth: _____ ❑ OP1X ❑ OP-R

Social Security #: _____

PLACE LABEL HERE

Type of Order: ❑ STAT ❑ Routine

Reports by ❑ Mailbox ❑ Fax (#) _____

❑ Patient to wait for phone / fax results ❑ **Phone Rept (#)** _____

WOMEN'S HEALTH ORDERS

	MAMMOGRAPHY	
	● **SCREENING MAMMOGRAM** ***ASYMPTOMATIC PATIENTS***	
	BILATERAL 2 VIEW STUDY	Women's Wellness
	UNILATERAL 2 VIEW STUDY RT LT	Women's Wellness
	● **DIAGNOSTIC MAMMOGRAM** – ***PATIENTS WITH SIGNS OR SYMPTOMS OF BREAST DISEASE, OR PREVIOUS RADIOGRAPHIC FINDINGS REQUIRING FOLLOW-UP***	
	BILATERAL	
	UNILATERAL STUDY **RT LT**	
	ADDITIONAL VIEWS PER MAMMOGRAM REPORT DATED: / /	**RT LT BILAT.**
	6 MONTH FOLLOW-UP PER MAMMOGRAM REPORT DATED: / /	**RT LT BILAT.**
	BREAST BIOPSY/ASPIRATION/LOCALIZATION	
	ULTRASOUND GUIDANCE, **BIOPSY RT LT**	
	CORE NEEDLE BIOPSY **RT LT**	
	ULTRASOUND GUIDANCE, **ASPIRATION RT LT**	
	PUNCTURE ASPIRATION, CYST **RT LT**	
	.....EACH ADDITIONAL CYST	
	GUIDANCE-PLACEMENT, **NEEDLE WIRE LOCALIZATION RT LT**	
	.....EACH ADDITIONAL LESION	
	MISCELLANEOUS	
	DEXA SCAN (BONE DENSITOMETRY)	❑ SADC ❑ SAMH
	DUCTOGRAM **RT LT**	
	HYSTEROSALPINGOGRAM	
	SCINTIMAMMOGRAPHY	
	SENTINEL NODE (LOCALIZATION)	
	ULTRASOUND	
	BIOPHYSICAL PROFILE	
	BREAST SONOGRAM **RT LT**	
	PELVIC SONOGRAM	
	OB 1st TRIMESTER SONOGRAM	
	OB COMPLETE 13-40 WEEKS	
	OB AMNIOCENTESIS	
	TRANSVAGINAL ONLY	
	OTHER EXAMS:	
	INSTRUCTIONS:	
	SCHEDULED DATE & TIME:	

ORDERING PHYSICIAN SIGNATURE* _____ DATE.TIME _____

Additional copies to: _____

● SIGNATURE STAMP UNACCEPABLE AUTHENTICATION. PLEASE SIGN.

REGISTRATION FAX #: 347-1377