

**HUNTINGTON HOSPITAL - WOMEN'S HEALTH CENTER**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Patient History/Diagnosis: \_\_\_\_\_

- |   |  |  |
|---|--|--|
| Mammography                               | Bilateral                                | Unilateral   |
|   | <input type="checkbox"/> Left            | <input type="checkbox"/> Right                             |
| Breast Ultrasound                         | <input type="checkbox"/> Bilateral       | <input type="checkbox"/> Unilateral                        |
|   | <input type="checkbox"/> Left            | <input type="checkbox"/> Right                             |
|   | <input type="checkbox"/> Cyst Aspiration | <input type="checkbox"/> Core Biopsy                       |
| Galactogram                               | <input type="checkbox"/> Left            | <input type="checkbox"/> Right                             |
| Wire Localization                         | <input type="checkbox"/> Left            | <input type="checkbox"/> Right                             |
|   | <input type="checkbox"/> Mammo           | <input type="checkbox"/> Sono <input type="checkbox"/> MRI |
| Stereotactic Biopsy                       | <input type="checkbox"/> Left            | <input type="checkbox"/> Right                             |
| Breast MRI                                | <input type="checkbox"/> Bilateral       | <input type="checkbox"/> Unilateral                        |
| MRI Biopsy                                | <input type="checkbox"/> Left            | <input type="checkbox"/> Right                             |
| <input type="checkbox"/> Bone Density     |  |  |
| <input type="checkbox"/> Bone Density VFA |  |  |

**Procedure Code:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_