Touchstone MEDICAL IMAGING

San Antonio Stone Oak
18802 Meisner Drive
San Antonio, TX 78258
210-614-0600
Fax: 210-614-1611

ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

Appt. Date ______________

Appt. Time ______________

Patient Name: ______________ Sex: ☐ Male ☐ Female DOB: ______________

Cell Phone: ______________ Home/Work Phone: ______________

Insurance: ______________

Insurance ID#: ______________ Authorization: ______________

Referring Physicians Signature:

☐ **STAT**

☐ **CALL** ______________

______________ May modify exam at radiologists discretion if clinically indicated

______________ Scan as Ordered

______________ Cell phone #

Print Referring Dr.: ______________ Referring Office Contact: ______________

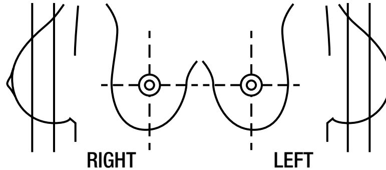
Date Ordered: ______________ Office Phone: ______________ Office Fax: ______________

❍ Screening Mammogram w/ call back visit: If a screening mammogram is abnormal, inconclusive, or questionable, then perform these additional diagnostic exams: diagnostic mammogram/sonogram

❍ Screening Mammogram **(Routine/No Problems)**

Symptomatic Exam

❍ Diagnostic Mammogram with Breast Ultrasound, if needed – ☐ Left ☐ Right ☐ Bilateral



Please check a diagnosis:

- ☐ Abnormal mammogram
- ☐ Follow-up to biopsy
- ☐ History of breast cancer
- ☐ Lump
- ☐ Pain
- ☐ Follow-up to previous reported abnormal findings
- ☐ Other ______________

❍ Bilateral Breast MRI (with second look breast ultrasound if needed)
☐ with and without contrast (lesion detection)
☐ without contrast (for implant integrity only)

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- ☐ Other ______________

❍ Bone Density/Osteoporosis Screening
______________ Diagnosis

❍ **MRI:**
Exam Requested ______________

☐ With/Without Contrast ☐ Without Contrast

❍ **CT:**
Exam Requested ______________

☐ Without ☐ With ☐ With/Without

❍ **US:**
Exam Requested ______________

❍ **X-Ray:**
Exam Requested ______________

❍ **Fluoroscopy:**
Exam Requested ______________

To expedite interpretation, have the patient bring previous mammogram exam reports and images.