

PATIENT LABEL

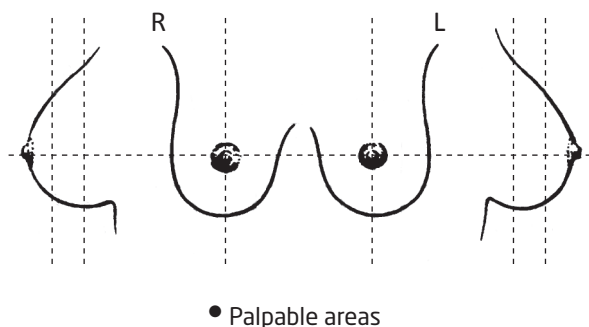
**LAKE FOREST HOSPITAL
REQUEST FOR BREAST IMAGING EXAM
847.535.6198**

PATIENT NAME		DATE OF BIRTH	DATE OF ORDER
ORDERING MD	ICD-10 CODE		
ADDRESS	<input type="checkbox"/> Z12.31 Screening mammogram	<input type="checkbox"/> R92.8 Abnormal mammogram	
PHONE NUMBER	<input type="checkbox"/> N63 Unspecified lump in breast	<input type="checkbox"/> Z85.3 Personal history of breast cancer	
	<input type="checkbox"/> N64.59 Other signs/symptoms	<input type="checkbox"/> Z80.3 Family history of breast cancer	
	<input type="checkbox"/> Other _____		

If any of the following are checked, the patient will be placed on the clinical pathway:

<input type="checkbox"/> SCREENING MAMMOGRAM <input type="checkbox"/> Asymptomatic routine mammogram <input type="checkbox"/> Augmentation Implants, asymptomatic <input type="checkbox"/> Other _____ <input type="checkbox"/> WHOLE BREAST SCREENING ULTRASOUND <input type="checkbox"/> MRI SCREENING/DIAGNOSTIC <input type="checkbox"/> MRI IMPLANT EVALUATION	<input type="checkbox"/> DIAGNOSTIC MAMMOGRAM <input type="checkbox"/> Abnormal mammogram <input type="checkbox"/> Short interval follow-up <input type="checkbox"/> Palpable lump or thickening <input type="checkbox"/> Previous lumpectomy <input type="checkbox"/> Abnormal nipple discharge <input type="checkbox"/> Other _____ <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL	<input type="checkbox"/> ULTRASOUND <input type="checkbox"/> Abnormal mammogram <input type="checkbox"/> Short interval follow-up <input type="checkbox"/> Palpable lump or thickening <input type="checkbox"/> Possible breast abscess <input type="checkbox"/> Abnormal nipple discharge <input type="checkbox"/> Other _____ <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	PROCEDURES <input type="checkbox"/> Stereotactic-guided biopsy <input type="checkbox"/> Ultrasound-guided biopsy <input type="checkbox"/> Ductogram <input type="checkbox"/> Cyst aspiration <input type="checkbox"/> Drainage <input type="checkbox"/> Pre-operative needle localization <input type="checkbox"/> Other _____ <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL
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OPT OUT of clinical pathway: Please specify _____

LOCATION OF CLINICAL CONCERN <input type="checkbox"/> RT UOQ <input type="checkbox"/> LT UOQ <input type="checkbox"/> RT UIQ <input type="checkbox"/> LT UIQ <input type="checkbox"/> RT LIQ <input type="checkbox"/> LT LIQ <input type="checkbox"/> RT LOQ <input type="checkbox"/> LT LOQ <input type="checkbox"/> SUBAREOLA <input type="checkbox"/> AXILLA Size of abnormality _____ _____ _____	REASON FOR EXAM/CONCERN  <p>• Palpable areas</p>
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Time _____ Date _____ Requesting Physician Signature _____

Northwestern Medicine Lake Forest Hospital
1000 North Westmoreland Road
Lake Forest, Illinois 60045

Northwestern Medicine Lake Forest Hospital Grayslake
1475 East Belvidere Road
Grayslake, Illinois 60030

Northwestern Medicine Lake Forest Hospital Vernon Hills
870 North Milwaukee Avenue
Vernon Hills, Illinois 60060

Northwestern Medicine Lake Forest Hospital Gurnee Tower
25 Tower Court
Gurnee, Illinois 60031

Northwestern Medicine Lake Forest Hospital Glenview
2701 Patriot Blvd. Suite 175
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