Breast Imaging Specialists

Physician Requisition Form

15195 National Ave, Suite 201
Los Gatos CA 95032
408.800.5BIS (5247)
fax 408.356.5526
info@eBreastImaging.com

Dipa H. Patel, MD

Softer mammogram™ PROVIDER

Name: _____ Date of Birth: _____

Phone: _____

Has the patient had any prior mammograms? **Y** ☐ **N** ☐ If Yes, Where and when? _____

Routine annual exam:

R ☐ **L** ☐ **B** ☐ Low Dose 3D Screening Mammography with Tomosynthesis and C-View Technology
R ☐ **L** ☐ **B** ☐ 3D Breast Ultrasound for Dense Tissue

Diagnostic study: (Tomosynthesis/ultrasound will be performed if indicated)

History/Clinical: _____

R ☐ **L** ☐ **B** ☐ Follow up breast cancer
R ☐ **L** ☐ **B** ☐ Palpable lump
R ☐ **L** ☐ **B** ☐ Breast Pain
R ☐ **L** ☐ **B** ☐ Thickening
R ☐ **L** ☐ **B** ☐ Follow-up prior imaging

R ☐ **L** ☐ **B** ☐ Nipple discharge color: _____
R ☐ **L** ☐ **B** ☐ Other: _____

3D Ultrasound:

R ☐ **L** ☐ **B** ☐ History: _____

Procedures:

R ☐ **L** ☐ **B** ☐ Ultrasound Guided Procedures: Core biopsy ☐ Aspiration ☐
R ☐ **L** ☐ **B** ☐ Stereotactic Core Biopsy
R ☐ **L** ☐ **B** ☐ Special procedures: Ductography ☐ J-wire placement ☐
R ☐ **L** ☐ **B** ☐ Contrast Enhanced Mammography

Bone Densitometry ☐ Body Scan/BMI ☐ 2nd Opinion/Film Review ☐ MRI Review ☐

Physician Name/Signature: _____ Ph: _____ Fax: _____

CC: _____ Ph/Fax: _____ Date: _____

An American College of Radiology Center of Excellence Facility