BOSTON BREAST DIAGNOSTIC CENTER

Elsie Levin, M.D.
Medical Director

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James M. Snider, M.D.
Diagnostic Breast Radiologist

REQUEST FOR BREAST MRI

Patient Name:_____ DOB:_____

Referring Physician:_____

Phone #_____ Fax # _____

REASON FOR EXAM: _____

_____

_____

INSURANCE ID #_____ **GROUP #** _____

PRE-AUTH # _____ **VALID** _____

Physician signature:_____ Date:_____

GUIDELINES FOR SCHEDULING:

- **Schedule between days 7-14 of menstrual cycle.**
- Remind patient to check to see if their insurance requires pre-authorization
- Remind patient to bring most recent mammogram & ultrasound images if from an outside facility.

Please fax consult request to Boston Breast Diagnostic Center at 617-553-5353