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Elsie Levin, M.D.
Medical Director

James M. Snider, M.D.

REQUEST FOR MAMMOGRAPHY/BREAST IMAGING

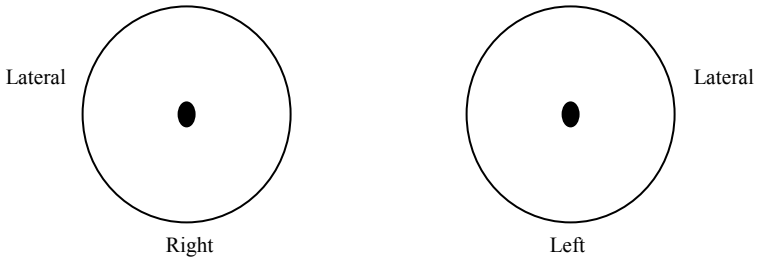
Patient Name:_____ D.O.B:_____

Referring Physician:_____

- ☐ Screening Mammogram
- ☐ Diagnostic Breast Consultation & Breast Imaging Studies

Reason for consult:_____

_____



Please indicate the area of clinical concern on diagram, including size.

Physician signature:_____ Date:_____

To the Patient:
Your appointment is scheduled on: Date:_____ Time:_____

You are scheduled to be evaluated by a diagnostic Radiologist who specializes in breast disease. You will be having imaging studies which may include a mammogram, a clinical breast exam, an ultrasound and if necessary, a needle biopsy or cyst aspiration. The Radiologist will discuss the results with you and answer any questions you may have at that time. It is important for you to bring any prior mammogram films with you.

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