PLEASE PRINT	SOCIAL SEC. #:	UNIT #:	DATE:
PATIENT:	DATE OF BIRTH:	HOME #:	CONTACT #:
REFERRING ATTENDING:	PHONE #:	FAX #:	
INSURANCE:	AUTH # (IF APPLICABLE):	# VISITS APPROVED:	EXPIRATION DATE:

REQUIRED

ALLERGIES: ____

REASON FOR TEST: ____

☐ SCREENING MAMMOGRAM			
☐ DIAGNOSTIC MAMMOGRAM BILATERAL			
☐ DIAGNOSTIC MAMMOGRAM UNILATERAL	☐ Right	☐ Left	
☐ BREAST TOMOSYNTHESIS	☐ Bilateral	☐ Right	☐ Left
☐ BREAST ULTRASOUND (76645)	☐ Bilateral	☐ Right	☐ Left
☐ 3-D BREAST RECONSTRUCTION (76377)	☐ Bilateral	☐ Right	☐ Left
☐ STEREOTACTIC BREAST BIOPSY (77031)	☐ Bilateral	☐ Right	☐ Left
☐ ULTRASOUND GUIDED BREAST BIOPSY (76942)	☐ Bilateral	☐ Right	☐ Left
☐ ULTRASOUND GUIDED FINE NEEDLE ASPIRATION (76942)	☐ Bilateral	☐ Right	☐ Left
☐ I-125 SEED LOCALIZATION (77032)	☐ Bilateral	☐ Right	☐ Left
☐ GALACTOGRAM (77053)	☐ Bilateral	☐ Right	☐ Left
☐ LYMPHOSCINTIGRAPHY (78195)	☐ Bilateral	☐ Right	☐ Left
☐ BONE DENSITY, DEXA (77080)			
☐ BREAST MRI BIOPSY WITHOUT & WITH CONTRAST (77021)	☐ Bilateral	☐ Right	☐ Left
☐ BILATERAL BREAST MRI WITHOUT & WITH CONTRAST (C8908)			

____
Printed Practitioner Name

____ ______________ ______________________
Practitioner Signature Provider # Date and Time

Signature certifies medical necessity of above ordered testing.

Department of Radiology Breast Center Order
Shands Jacksonville Medical Center, Inc.
Central Scheduling (904)383-1024

06/05/13