



**Ellen Shaw de Paredes Institute for Women's Imaging**

**4480 Cox Road, Suite 100  
 Glen Allen, VA 23060  
 (804) 523 2303  
 FAX (804) 523 3210**

Appointment Requested    Date: \_\_\_\_\_    Time: \_\_\_\_\_  
 Name: \_\_\_\_\_    DOB: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home#: \_\_\_\_\_    Work#: \_\_\_\_\_  
 Insurance: \_\_\_\_\_

**IF ANY ANSWER IN 1- 4 IS YES, THE MAMMOGRAM MUST BE SCHEDULED AS A DIAGNOSTIC EXAM.**

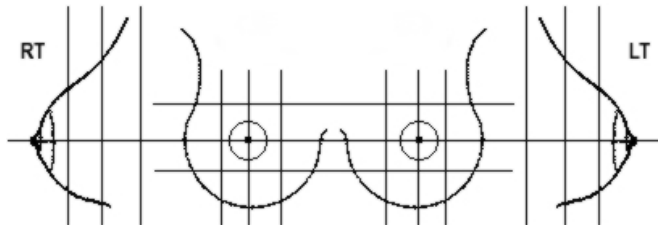
	<b>Screening</b>	<b>Diagnostic</b>
1) Does the Patient Have a Breast Lump or Nipple discharge?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2) Does the Patient Have Breast Implants?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
3) Has the Patient Had Breast Cancer Treated Without Mastectomy?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
4) Is this a Follow-up of an Abnormal Mammogram?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

**If the Patient has Breast Pain during the Month, Please Schedule Screening When Breasts are Least Tender.**

Other Pertinent Clinical History: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physical Exam: (see diagram)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Date of Breast Exam: \_\_\_\_\_  
 Clinical Impression \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the patient wish to be seen by the radiologist?    **Yes**     **No**

MD Name \_\_\_\_\_    Signature \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone or Beeper \_\_\_\_\_    FAX \_\_\_\_\_

**Unless this box is checked, additionally, breast ultrasound may be performed as needed.**