



1POREF001

Place Patient Label  
Inside This Box

7040.03.15772.03.lee Sunset Date: 5/2023

Name:	Sex:	Date of Birth:	Age:	SS#:
Telephone: (Home)	(Work)	(Mobile)	PreCert/Auth#:	
Physician Ph#	Physician Fax#:	Print Name of Physician:		

**Physician Signature (Required)** \_\_\_\_\_ **Date/Time (Required):** \_\_\_\_\_

<input type="checkbox"/> APPOINTMENT REQUESTED THROUGH SCHEDULING SYSTEM	Appointment Date/Time:	<input type="checkbox"/> Spoke to patient	<input type="checkbox"/> Left message for Patient	<input type="checkbox"/> No answer
--	------------------------	---	---	------------------------------------

**IF SCHEDULING VIA FAX, PLEASE INCLUDE THE FOLLOWING INFORMATION:** Day of the week: \_\_\_\_\_ Preference:  Morning  Afternoon

**Please fax form to Central Scheduling at (910) 715-1177. Scheduling will contact the patient.**

**ATTENTION PATIENT: Please bring a written list of all your current medications.**

**If you have not been contacted within one business day about your appointment, please call (910) 715-2778 or (866) 415-2778.**

**CHECK PROCEDURE AND INSERT ICD-10 CODE**

2D Mammography		CPT	DX CODE
<input type="checkbox"/>	2D Diagnostic Bilateral Also order Ultrasound Breast if medically necessary	77066 7664250	
<input type="checkbox"/>	2D Diagnostic Unilateral <input type="checkbox"/> L <input type="checkbox"/> R Also order Ultrasound Breast if medically necessary	77065 76642	
<input type="checkbox"/>	2D Screening Bilateral	77067	
<input type="checkbox"/>	2D Screening Unilateral <input type="checkbox"/> L <input type="checkbox"/> R	7706752	
3D Mammography		CPT	DX CODE
<input type="checkbox"/>	3D Screening Bilateral	77067 77063	
<input type="checkbox"/>	3D Screening Unilateral <input type="checkbox"/> L <input type="checkbox"/> R	7706752 7706352	
<input type="checkbox"/>	3D Diagnostic Bilateral Also order Ultrasound Breast if medically necessary	77066 G0279 7664250	
<input type="checkbox"/>	3D Diagnostic Unilateral <input type="checkbox"/> L <input type="checkbox"/> R Also order Ultrasound Breast if medically necessary	77065 G0279 7664250	

Bone Density		CPT	DX CODE
<input type="checkbox"/>	Dexascan- Bone Density only	77080	

Comments: \_\_\_\_\_

**Please answer the following questions prior to scheduling the patient.**

When was the patient's last screening Mammogram? \_\_\_\_\_

Where are the patient's prior mammography's images? \_\_\_\_\_

Is this the first mammogram for the patient?  Yes  No

Does the patient have breast implants?  Yes  No

Has the patient been diagnosed with breast cancer within the last 5 years?  Yes  No

---

**\*\*Special Instructions to Ordering Physician:**

**ATTENTION PATIENT: Please bring a written list of all your current medications.**

*We request that patients arrive at the registration desk thirty minutes prior to the scheduled appointment, unless otherwise specified.*

