Los Angeles Department of Health Services
Breast Screening and Diagnostics Referral Form

Scheduling Fax (310) 533-4043
Incomplete forms cannot be processed

Instructions: Please complete section 1 for ALL patients to schedule the most appropriate evaluation. If the patient has a suspicious breast finding, please also complete section 2 for a diagnostic imaging request. If the patient has prior imaging please ask her to bring films or digital images of at least 2 mammograms in the last 5 years PRIOR to arriving for the radiology appointment.

Section 1 - Screening: (required for all patients)

Patient Age: _______
Date of last mammogram: ____________
Imaging Center Name: ______________ (if known)

Previous Mammogram density: □ Fatty □ Scattered □ Heterogeneous □ Extreme (if known)

<table>
<thead>
<tr>
<th>Patient History</th>
<th>No</th>
<th>Yes</th>
<th>Age at diagnosis</th>
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</thead>
<tbody>
<tr>
<td>1) Personal history of breast cancer?</td>
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<td>2) Personal history of ovarian cancer</td>
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<td>3) Breast cancer in a primary relative &lt;50 yo?</td>
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<td>4) Patient is a BRCA mutation carrier?</td>
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<td>5) Prior breast biopsy showing atypia?</td>
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<td>6) Prior breast surgery (breast implants)?</td>
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Section 2 – Request for Diagnostic Imaging:

If abnormal screening mammogram, have the patient obtain the digital images or films of the abnormal test. If there is a new abnormal finding, please complete the following (check all that apply):

□ Abnormal mammogram
Category (required) □ zero □ 3 □ 4 □ 5
□ Pathological nipple discharge □ New nipple inversion
□ Inflammatory skin changes
□ Palpable mass (mark location on diagram) size: ______ cm
  □ irregular/fixed □ ulcerated □ enlarged lymph nodes □ skin changes
□ Other __________

Patient phone number(s) for scheduling: ______
Patient ID: ______

1) ______________________________
2) ______________________________

Ordering Provider: ____________________________
Office Phone: ____________________________
Place stamp here (name and DOB)