



Ph. (956) 668-8282 • Fax (956) 668-8181

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

\*Clinical Diagnosis / Symptoms (Required): \_\_\_\_\_

Apt. Date: \_\_\_\_\_ Time: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Office Phone# \_\_\_\_\_ Office Fax: \_\_\_\_\_ Office Email: \_\_\_\_\_

OBTAIN INS. AUTH.  CALL PATIENT TO SCHEDULE  TRANSPORTATION  STAT REPORT  ROUTINE REPORT

### 3D MAMMOGRAPHY

- \_\_\_ Digital Screening
- \_\_\_ Digital Unilateral Diagnostic Right Left
- \_\_\_ Digital Bilateral Diagnostic
- \_\_\_ Compression Spot Views
- \_\_\_ Other \_\_\_\_\_

Mammography Accredited by



### ELASTOGRAPHY

- \_\_\_ Breast with Elastography
- \_\_\_ Liver with Elastography
- \_\_\_ Thyroid with Elastography

### BREAST MRI

- With and Without Contrast  Without Contrast
- \_\_\_ MRI Breast
- Bilateral  Unilateral Left Right

### ULTRASOUND

- |   |  |
|---|--|
| ___ Abdomen, Single Organ/Quadrant  | ___ Liver  |
| ___ Abdomen Total   | ___ Pelvic - Transabdominal  |
| ___ Aorta Duplex  | ___ Retroperitoneal  |
| ___ Arterial Lower Extremity Duplex   | <input type="checkbox"/> Limited (Renal) <input type="checkbox"/> Complete (Renal & Bladder) |
| <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral Left Right | ___ Renal Arteries (Abdomen Aorta, IVC)  |
| ___ Arterial Upper Extremity Duplex   | ___ Scrotum (Testicular) Duplex  |
| <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral Left Right | ___ Thyroid  |
| ___ Bladder (Pre & Post Void)   | ___ Venous Upper Extremity   |
| ___ Breast  | <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral Left Right            |
| <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral Left Right | ___ Venous Lower Extremity   |
| ___ Carotid Duplex  | <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral Left Right            |
| ___ Complete Extremity Non-Vascular   | ___ Other _____  |
| <input type="checkbox"/> Upper <input type="checkbox"/> Lower Left Right          |  |

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[www.McAllenBreastImaging.com](http://www.McAllenBreastImaging.com)