ROCKLEDGE MRI AND PET IMAGING CENTER

1910 Rockledge Blvd. Suite 102
Rockledge, FL 32955

BREAST MRI INFORMATION REQUEST AND CHECKLIST

Preliminary information is required for all Breast MRI patients, in addition to submitting a general imaging request form with the provider's signature. It is important to obtain the following information prior to the patient's scheduled exam for radiologist's protocoling of the study and to verify insurance coverage.

Patient Name______________________________DOB_________________

Height____________Weight_____________ BUN_____ CREATININE_____ Date drawn _______

Referring Physician____________________

EXAMINATION AND INDICATION (Please check)

_____MRI Breast w/contrast
_____Recent diagnosis of breast cancer-staging
_____Previous diagnoses of breast cancer
_____left ____right , Type of cancer ______________________________________

_____High Risk Breast MRI per ACS guidelines (after mammogram)
_____Breast cancer gene (BRCAI or 2) mutation carriers-serum positive
_____First-degree relative of BRCA carrier, but untested
_____Lifetime risk 20-25% or greater, ad defined by BRCAPRO statistical model
_____Radiation to chest between age 10 and 30 years

_____MRI Guided Breast Biopsy _____Left _____Right

_____MRI Breast w/contrast with Silicone Implant Evaluation

_____Implants-suspect rupture, no suspicion of cancer

IMPORTANT CLINICAL INFORMATION:
PLEASE FAX THIS FORM TO 321-636-6614 AND CALL WITH ANY QUESTIONS 321-636-6599

_____Fax clinical notes on patient history and breast physical examination
_____Fax clinical breast biopsy pathology results
_____Fax pathology reports

_____Breast Surgery: ______left, ______right, Date of Surgery____________ Surgeon_______________

Type of surgery performed: _____ lumpectomy, ______mastectomy, _____reduction,

_____ augmentation, other (list) ______________________________
____

Breast Biopsy History: Stereotactic_____ Ultrasound_____ Dates ____________

History of Radiation Therapy? Yes_____ No _____ When completed__________

Date of last Menstrual Cycle __________ (Exams scheduled between day 5 and 14 of cycle)

Post-menopausal? _______

On Birth Control Pills Yes_____ No_____ Lactating? Yes_____ No_____

Hormone Replacement Therapy? Yes____ No_____

Have previous Mammogram/Ultrasound Films and Reports been requested? Yes____ No____

Are they being sent to us? Yes_____ No_____

Other notes and requests ____
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