



Comprehensive Breast Center

281.580.6171

www.tops-breastcenter.com

Scheduling Fax Line at 281-754-4486

Leading the Way 3D Mammography

HOUSTON
17030 Red Oak Drive
Houston, TX 77090

THE WOODLANDS
111 Vision Park Blvd.
Suite 230
The Woodlands, TX 77384

KINGWOOD
350 Kingwood Medical Dr.
Suite 110
Kingwood, TX 77339

WILLOWBROOK
13215 Dotson Rd
Suite 220
Houston, TX 77070

Patient Information:

Patient Name: _____ DOB: _____

Patient Phone Number: _____ Date: _____

Physician: _____

Examination Request:

- | | | |
|--|---|---------------|
| <input type="checkbox"/> Screening Mammogram w/ additional views and/or Ultrasound if necessary for inconclusive Mammogram | <input type="checkbox"/> Breast Ultrasound | R_____ L_____ |
| <input type="checkbox"/> Screening Mammogram | <input type="checkbox"/> Breast Biopsy w/post procedure Mammogram if needed | R_____ L_____ |
| <input type="checkbox"/> Diagnostic Mammogram w/Ultrasound if necessary | <input type="checkbox"/> Cyst Aspiration | R_____ L_____ |
| <input type="checkbox"/> Unilateral Mammogram R_____ L_____ | <input type="checkbox"/> Fine Needle Aspiration | R_____ L_____ |
| <input type="checkbox"/> Breast Ultrasound for Dense Breasts | <input type="checkbox"/> Ductogram | R_____ L_____ |
| <input type="checkbox"/> Additional views and/or Ultrasound if necessary for inconclusive Mammogram | <input type="checkbox"/> Contrast Enhanced Mammography with Ultrasound if necessary - Bilateral | |
| <input type="checkbox"/> Other _____ | | |

Select Reason for Procedure:

- | | | |
|--|--|---|
| <input type="checkbox"/> Breast Mass / Lump | <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Breast Cyst |
| <input type="checkbox"/> Family History of Breast Cancer | <input type="checkbox"/> Personal History of Breast Cancer | <input type="checkbox"/> Abnormal Mammogram |
| <input type="checkbox"/> Discharge / Color: _____ | <input type="checkbox"/> Other _____ | |

Bone Densitometry:

- DEXA Bone Densitometry

Select Reason For Procedure:

- | | | |
|---|--|---|
| <input type="checkbox"/> Screening for Osteoporosis | <input type="checkbox"/> Post-Menopausal, Natural Status | <input type="checkbox"/> Post-Menstrual, using HRT |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Long-term, current, use of steroids or high-risk medications |
| <input type="checkbox"/> Other _____ | | |

Physician Signature: _____

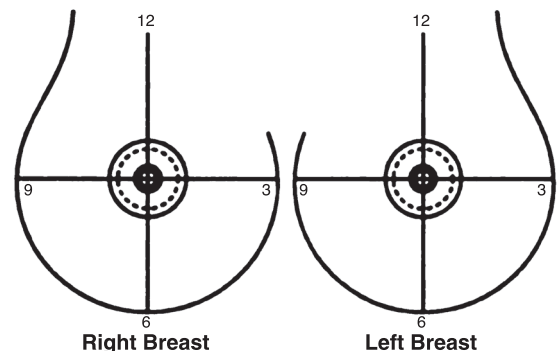
For Clinical Use Only - Please Indicate Area of Concern

TO THE PATIENT:

Telephone ahead to schedule an appointment **281-580-6171**

It is important that you bring this Order Form with you the day of your appointment.

Please bring your photo identification card and insurance card on the day of your appointment. Children under the age of 12 are not permitted in exam rooms and cannot be left unattended in the waiting areas. Failure to comply with this safety policy will result in the rescheduling of your appointment.



Facility addresses and information on reverse side