NORTHSIDE HOSPITAL
BREAST IMAGING SERVICES

CENTRALIZED SCHEDULING →
404 851-6577

Fax orders: 404-851-6188 Website: www.northside.com

PLEASE CHECK CORRECT LOCATION FOR PATIENT

- ❑ NORTHSIDE ALPHARETTA/WOMENS IMAGING
- ❑ NORTH CRESCENT WOMEN'S IMAGING (770) 667-4370
- ❑ BREAST CARE CENTER
- ❑ NORTHSIDE JOHNS CREEK IMAGING
- ❑ MERIDIAN MARK OUTPATIENT IMAGING
- ❑ OUTPATIENT RADIOLOGY/980 BLDG.
- ❑ INTERCHANGE MAMMOGRAPHY CENTER (404) 459-1600

Patient Name ______________________________

Day Phone ______________________ DOB ____________

Registration Time ________ Appt. Time ________ Appt. Date ________

Reason/Diagnosis for Exam ______________________________

Confirmation # ________________ ICD-9 Code ____________

Referring Physician ______________________________

Office ________________ Telephone ________________

SPECIAL REQUESTS – Please check all that apply.

- ❑ STAT Call Report # ____________
- ❑ Send Film with patient
- ❑ Send Film by courier
- ❑ FAX
  (If different than AUTOFAX #) ____________
- ❑ Mail to:
  (If different from primary office) ____________

MAMMOGRAM PREP:
No powder or deodorant or cream the day of the exam.

Please bring previous films and report if not done at a Northside Hospital facility.

Breast Exam Comments

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❑ **Screening Mammogram** (Routine - no problems)
- ❑ Change to Diagnostic if indicated or add ultrasound if indicated.

❑ **Diagnostic Mammogram** (Right, Left, Bilat)
Indicate area of concern on diagram below.
Reason ____________________
- ❑ Add Ultrasound if indicated.
- ❑ Aspirate or Biopsy if indicated.

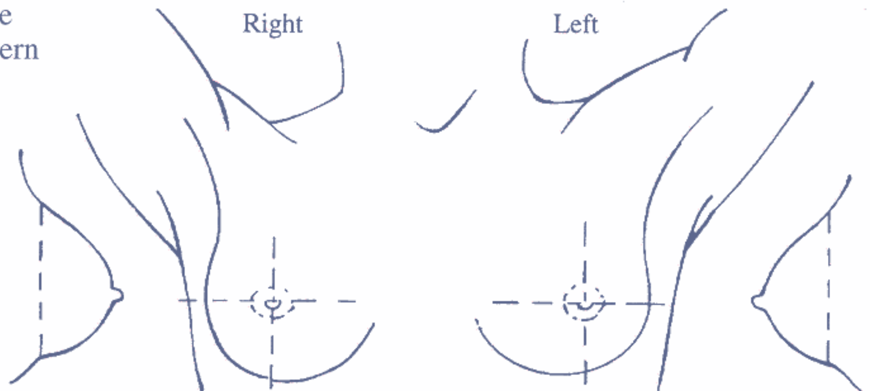
❑ **Breast Ultrasound** (Right, Left, Bilat)*
(Please indicate area of concern.)
*NOTE: We do not perform screening ultrasound. As recommended in the guidelines of the American College of Radiology, we target ultrasound to areas of clinical concern on mammographic abnormality.
- ❑ Aspirate or Biopsy if indicated.

❑ **Ductogram** (Right, Left, Bilat)

❑ **Cyst Aspiration** (Right, Left, Bilat)
- ❑ Add Biopsy, if indicated

❑ **Core Biopsy** (Stereotactic or Ultrasound)
(Right, Left, Bilat) *(Circle One)*

Indicate Areas of Concern on Graphics

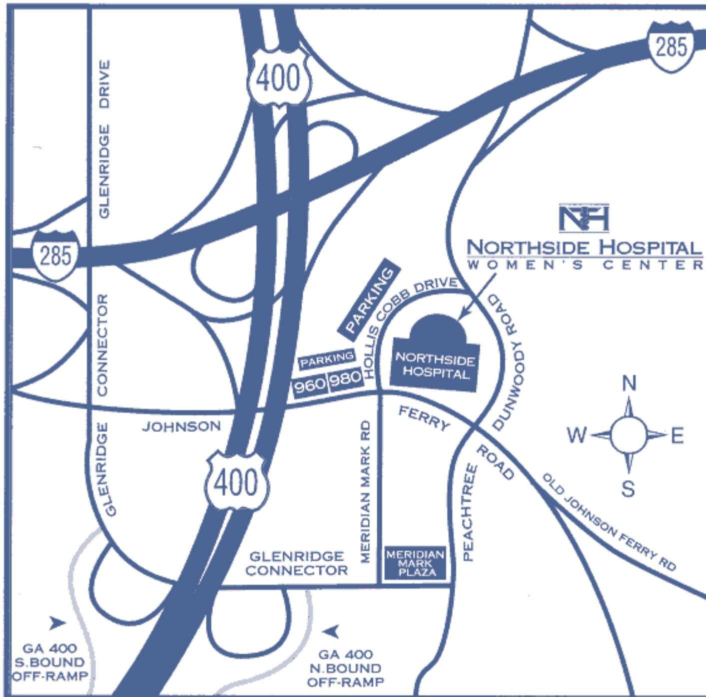


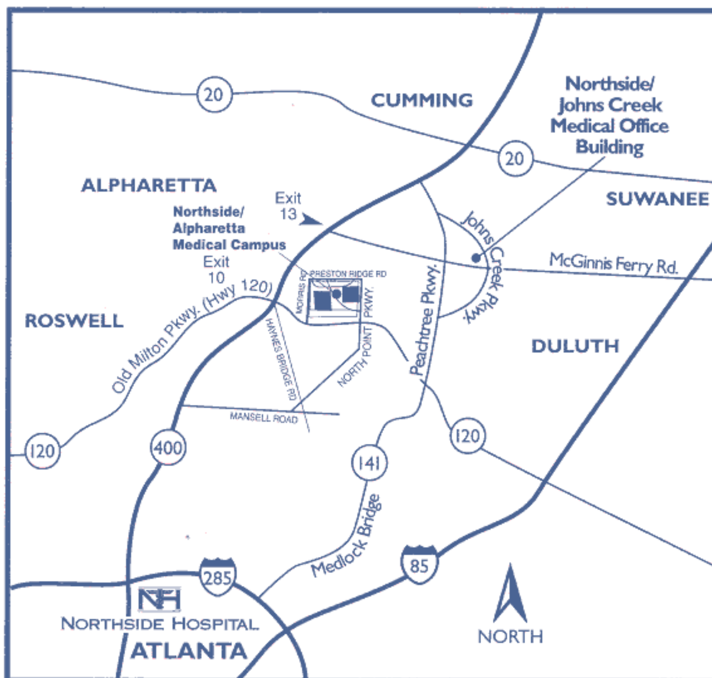
- Bring this completed form signed by your physician, and your insurance card with you to the Facility Registration/Testing Area. **Arriving for testing without this form signed by your physician may result in cancellation or delay of your test.**
- Radiology Professional services will be billed separately by Northside Radiology Associates, P.C. (tax id # 58-2244832) in addition to the test performed by a Northside Hospital Facility.
- Your insurance plan may consider your test/procedure a screening or a non-covered service. Please call your insurance company prior to your scheduled test date to check coverage and see if you need a referral.

Physician Signature ____________________ Date ____________________

MAPS AND OTHER INFORMATION ON BACK

RAD0003
Piedmont Graphics Rev. 06/04/04





FOR DIRECTIONS, CALL
(404) 303-3900
(Main Campus Area Only)

- **Northside**
  Alpharetta/Women's Imaging, Suite 145 -
  Ph: (770) 667-4280 Fax: (770) 667-4281
  3400-C Old Milton Pkwy.
  Alpharetta, GA 30005
- **Breast Care Center/**
  Women's Center
  1000 Johnson Ferry Rd.
  Atlanta, GA 30342
  Phone: (404) 845-5700
  Fax: (404) 845-5732
- **Northside**
  Johns Creek Imaging
  3890 Johns Creek Pkwy
  Suite 100
  Suwanee, GA 30024
  Phone: (678) 475-6595
  Fax: (678) 475-6601
- **Meridian Mark OP Imaging**
  5445 Meridian Mark
  Suite 450
  Atlanta, GA 30342
  Phone: (404) 459-1875
  Fax: (404) 459-1880
- **Outpatient Radiology**
  980 Johnson Ferry Rd.
  Suite 300
  Atlanta, GA 30342
  Phone: (404) 851-6363
  Fax: (404) 303-3403
- **North Crescent Women's Imaging**
  11975 Morris Road
  Suite 120
  Alpharetta, GA 30005
  Phone: (770) 667-4370
- **Interchange Mammography Center**
  5780 Peachtree Dunwoody Road
  Suite 100
  Atlanta, GA 30342
  Phone: (404) 459-1600