

City of Hope Orange County Lennar Foundation Cancer Center

Breast Screening & Diagnostic Center Referring Physician Order Form

Patient Name: _____ DOB: _____

Patient Phone Number: _____ Today's Date: _____

Referring Physician: _____ Phone Number: _____

Referring Physician Signature (Required): _____

☐ Screening Mammogram per City of Hope Protocol (no breast problems)

****Routine Examination: Includes asymptomatic patients with usual pain/tenderness or augmentation****

If abnormality found, follow up with additional exams-mammography, ultrasound, image-guided biopsy, and/or breast MRI.

☐ Diagnostic Evaluation Per City of Hope Protocol (mammography and/or ultrasound)

****Patient to bring this order to appointment ****

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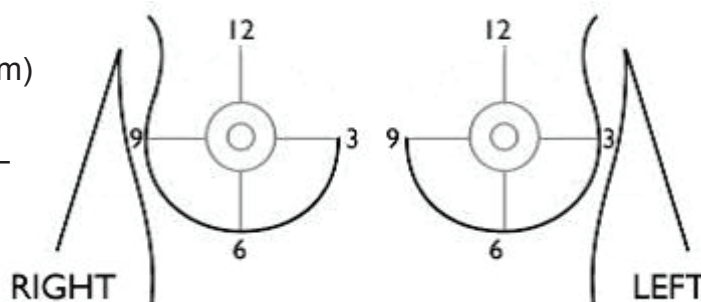
☐ Breast Lump/Mass (please mark location on diagram)

☐ Other _____

☐ Breast MRI:

☐ Evaluation of/for breast cancer, or high-risk screening patients (with/without contrast)

☐ Evaluation of implant integrity (without contrast)



☐ Bone Density Screening

Select Diagnosis Code Below (Required):

☐ N95.8 Other meno/perimenopausal disorder

☐ N95.9 Meno/Perimenopausal disorder NOS

☐ E28.310 Symptomatic premature menopause

☐ E28.319 Asymptomatic premature menopause

☐ M85.88 Osteopenia (Of Other Site)

☐ E28.39 Other primary ovarian failure

☐ E21.0 Primary Hyperthyroidism

☐ Z78.0 Asymptomatic menopausal state

☐ M81.0 Age-related osteoporosis w/o current fracture

☐ Other (must include ICD10 code): _____