Your Hospital's Logo Here

STEREOTACTIC WORKSHEET

HOSPITAL MAMMOGRAPHY CENTER

SCHEDULER:

DATE SCHEDULED:

PATIENT NAME:

DOB:

MEDICAL RECORD #:

REFERRING PHYSICIAN:

PHYSICIAN'S OFFICE #:

WILL THE REFERRING PHYSICIAN BE DOING THE PROCEDURE? ☐ YES ☐ NO

IF "NO", WHO IS THE RADIOLOGIST SCHEDULED?

DIAGNOSIS: Left / Right

OF BIOPSY SITES: Right: Left:

APPT DATE:

APPT TIME:

LOCATION of FILMS & PRIOR MAMMOGRAM REPORTS:

DATE FILMS & PRIOR MAMMOGRAM REPORTS DUE: (7 Days Prior)

DATE FILMS & REPORTS RECEIVED:

RADIOLOGIST

DATE FILMS REVIEWED: ☐ APPROVED ☐ DENIED

IF BX IS APPROVED, INDICATE LESION(S) AND SUGGESTED APPROACH:

IF BX IS DENIED, INDICATE REASON:

RADIOLOGIST'S SIGNATURE:

DATE:

PART OF THE MEDICAL RECORD