Your Hospital's Logo Here

NEEDLE LOCALIZATION WORKSHEET

HOSPITAL MAMMOGRAPHY CENTER

SCHEDULER:		DATE SCHEDULED:
PATIENT NAME:	DOB:	MEDICAL RECORD #:
SURGEON:		SURGEON'S OFFICE #:
DIAGNOSIS: Right / Left		
# OF BIOPSY SITES: Right:		Left:
APPT DATE:	APPT TIME:	SURGERY TIME:
LOCATION of FILMS & PRIOR MAMMOGRAM REPORTS:		
DATE FILMS & PRIOR MAMMOGRAM REPORTS DUE: (7 Days Prior)		
DATE FILMS & REPORTS RECEIVED:		
WHO IS THE RADIOLOGIST SCHEDULED?		

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