



Cambridge Health Alliance

Department of Radiology

Breast Imaging Service

Scheduling 617-665-1298

BREAST IMAGING REQUISITION

Name: _____ DOB: _____

MRN: _____

Date and Time of Appointment: _____

- Location: **Cambridge Hospital Campus**
 1493 Cambridge St. Cambridge, MA 02139; Tel.: 617-665-1000 Fax order to 617-665-1649
- Somerville Hospital Campus**
 230 Highland Avenue, Somerville, MA 02143; Tel.: 617-591-4500 Fax order to 617-591-4166
- Whidden Memorial Hospital Campus**
 96 Garland St. Everett, MA 02149; Tel.: 617-389-6270 Fax order to 617-394-7644

- Mammogram Screening Diagnostic
- Unilateral, Diagnostic Mammogram Right Left
- Right Breast Ultrasound _____ O'CLOCK POSITION
- Left Breast Ultrasound _____ O'CLOCK POSITION
- Breast Cyst Aspiration
- Stereotactic Breast Biopsy
- Ultrasound Guided Breast Biopsy
- Additional invasive imaging guided procedures as recommended
- Additional imaging procedures as recommended

Clinical History/Diagnosis: _____

Ordering provider _____ Phone/Beeper # _____

**PLEASE HAVE PATIENT BRING THIS FORM AT TIME OF EXAM AND FAX A COPY.
THE EXAM WILL NOT BE PERFORMED WITHOUT A COPY OF THIS ORDER!**