



Physician Requisition Form

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[eBreastImaging.com](http://BreastImaging.com)

Dipa H. Patel, MD



Name: Date of Birth:

Phone:

Has the patient had any prior mammograms? **Y** **N** If Yes, Where and when?

Routine annual exam:

- R** **L** **B** Low Dose 3D Screening Mammography with Tomosynthesis and C-View Technology
R **L** **B** 3D Breast Ultrasound for Dense Tissue

Diagnostic study: (Tomosynthesis/ultrasound will be performed if indicated)

History/Clinical:

- R** **L** **B** Follow up breast cancer
R **L** **B** Palpable lump
R **L** **B** Breast Pain
R **L** **B** Thickening
R **L** **B** Follow-up prior imaging



R **L** **B** Nipple discharge color:
R **L** **B** Other:

3D Ultrasound:

R **L** **B** History:

Procedures:

- R** **L** **B** Ultrasound Guided Procedures: Core biopsy Aspiration
R **L** **B** Stereotactic Core Biopsy
R **L** **B** Special procedures: Ductography J-wire placement
R **L** **B** Contrast Enhanced Mammography

Bone Densitometry **Body Scan/BMI** **2nd Opinion/Film Review** **MRI Review**

Physician Name/Signature: _____ Ph: Fax:

CC: Ph/Fax: Date: