Reset Form

COMPREHENSIVE BREAST CENTER

Pavilion for Women and Children • 900 Pacific Ave. • Everett, WA
425-258-7000 Option 3 • Fax 425-258-7035

1CONP

Name:_____ DOB:_____/ ____ / _____

Patient Phone: _____ Appointment Date: _____

TEC #: _____

Referring Clinician:_____ Clinician Phone: _____

☐ **Routine Screening - Asymptomatic**

☐ May schedule further imaging if indicated (signature required below)

PROBLEM SOLVING EVALUATION - REQUIRES PROVIDER SIGNATURE

Please provide information below

Diagnosis: _____ Diagnosis Code:_____

REASON:

☐ Early interval follow-up per M.D. from exam performed on: ____ / _____ /_____

☐ Pre-Radiation Therapy Work-up

☐ Baseline Post Treatment Work-up

☐ Further Imaging from screening exam performed on: _____ /_____ / _____ (see attached report)

☐ Short interval follow-up from exam performed on:_____ / ____ /_____ (see attached report)

☐ Symptomatic Evaluation (patient less than 30 years of age - ULTRASOUND ONLY)

☐ Symptomatic Evaluation (patient greater than 30 years of age) with ultrasound if indicated

☐ May schedule biopsy if indicated

☐ May schedule biopsy result appointment if indicated

☒ Permission to give biopsy results

☐ May schedule MRI if indicated

SYMPTOMS:

☐ Nipple Discharge ☐ Lump/mass palpated in the Supine / Sitting position ☐ Focal Breast Pain

(PLEASE CIRCLE POSITION)

☐ Other: _____

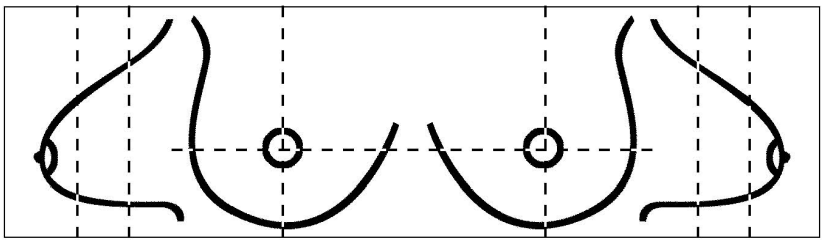
Please identify area of symptom below:

Side:_____

Quadrant:_____

Position:_____

Size:_____



Comments:_____

_____

PROVIDER SIGNATURE

DATE:_____TIME:_____ LIP SIGNATURE: _____ ID #: _____

PROVIDENCE Regional Medical Center Everett

Colby Campus • 1321 Colby Ave.
Pacific Campus • 916 Pacific Ave.
Pavilion for Women and Children • 900 Pacific Ave.
Providence Regional Cancer Partnership
1717 13th Street • Everett, WA 98201

PLACE PATIENT LABEL HERE

COMPREHENSIVE BREAST CENTER
(08/11) GUIDELINES ON BACK

29224 (6/20/20)

DO NOT WRITE OUTSIDE OF BORDER AREA