CENTRAL CAROLINA HOSPITAL

ORDERS MAY BE FAXED TO CCH PRE-REGISTRATION DEPARTMENT FAX: (919) 774-2276

WOMEN'S CENTER ORDER FORM

ROUTINE ☐ STAT ☐ SEND IMAGES W/PT ☐

Patient Instructions: Please call 708-4660 to pre-register.

PATIENT NAME (LAST / FIRST / MI)	SEX	DATE OF BIRTH	APPOINTMENT DATE AND TIME
REASON FOR TEST/PROCEDURE OR DIAGNOSIS	PATIENT PHONE NUMBER (HOME / WORK / CELL)		
	AUTHORIZATION NUMBER(S) FOR EACH PROCEDURE		
	DATE OF CREATININE	CREATININE	

VO / TO
Read Back ☐
By: ____________

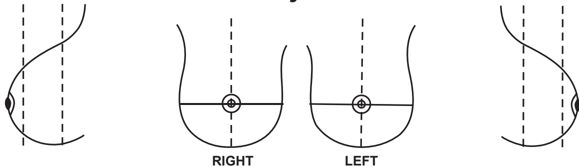
SPECIAL INSTRUCTIONS/COMMENTS ____________________

PROVIDER'S NAME *(PRINT)* ____________________ OFFICE PHONE # ____________

PROVIDER'S SIGNATURE ____________________ DATE ____________ TIME ____________ * Fax Results To: ____________

SIGNATURE STAMP NOT ACCEPTED ** All Results Will Be Faxed*

Please Indicate Any Areas of Concern



Date of last mammogram: ____________________

Where was last mammogram performed?

CCH ☐ * Other (Specify) ☐ ____________________

*If mammogram was performed at a site other than CCH, the patient is responsible for obtaining outside films for comparison prior to appointment time.

FOR TESTS WITH AN * PLEASE CALL 919-774-2157 TO SCHEDULE

X PLEASE REMEMBER TO SPECIFY LEFT OR RIGHT, AND AREA IF APPLICABLE

X	PROCEDURE	CPT	X	PROCEDURE	CPT	X	PROCEDURE	CPT
	Digital Mammo			**Breast Procedures**			**Ultrasound**	
	*BILATERAL SCREENING † See Note Below	G0202		*STEREOTACTIC BREAST BX ☐R ☐L	19081		*BREAST UNILATERAL LTD. (Limited / Focused Study) ☐R ☐L	76642
	*BILATERAL DIAGNOSTIC	G0204		*MAMMO-NEEDLE LOCALIZATION ☐R ☐L	19281		*BREAST UNILATERAL COMPLETE ☐R ☐L	76641
							*U.S. GUIDED BREAST BX ☐R ☐L	19083
	*BILATERAL DIAGNOSTIC Breast US Ltd. if indicated based on Diagnostic Mammo *PRE-CERT IF NECESSARY*	G0204 76642		*US-NEEDLE LOCALIZATION ☐R ☐L	19285		*U.S. GUIDED BREAST CYST & ASPIRATION ☐R ☐L	19000 76942
	*UNILATERAL DIAGNOSTIC ☐R ☐L	G0206					**Bone Densitometry**	
							*DEXA (Dual Energy X-Ray Absorptiometry)	77080
	*UNILATERAL DIAGNOSTIC Breast US Ltd. if indicated based on Diagnostic Mammo *PRE-CERT IF NECESSARY* ☐R ☐L	G0206 76642					*DEXA For patients over 350 lbs Bone Density/Appendicular	77081

† Request that CCH schedule and perform a diagnostic mammogram and/or ultrasound as indicated by the above screening results: YES ____________
(Please note this order does not cover a biopsy. A biopsy must be scheduled by the provider.)

PATIENT INSTRUCTIONS

Please Call 708-4660 to Pre-Register

Report directly to CCH Women's Center 20 minutes prior to your appointment Time

❑ **MAMMOGRAPHY**
1. Do not use deodorants or powder as this study is sensitive enough to detect them.
2. Bring all previous films and reports.

❑ **BIOPSY**
1. Bring all previous films and reports
2. Discontinue all aspirin, blood-thinning and anti-inflammatory medication 3 days prior to exam.
3. Light meal morning of procedure.

❑ **BREAST ULTRASOUND**
No preparation required.

❑ **BONE DENSITY**
No preparation required.
Wear elastic pants with no zipper or buttons if possible.

INSTRUCCIONES PARA EL PACIENTE

Por favor llame al 708-4660 para Pre-registrarse.

Reportese directamente al centro de la mujer (Women's Center) en el hospital 20 minutos antes de la hora de su cita.

❑ **MAMOGRAMA**
1. No use desodorantes o polvos perfumados. Este estudìo es muy sensitivo y podrá detectarlos.
2. Traiga todas las placas y todos los reportes anteriores.

❑ **BIOPSIA**
1. Traiga todas las placas y todas los reportes anteriores.
2. No tome aspirina, anticoagulantes, ni medi camentos anti-inflamatorios 3 dias antes del examen.
3. Comida ligera la mañana del procedimiento

❑ **ULTRASONIDO DEL SENO**
No requirere preparacion.

❑ **EXAMEN DE DENSIDAD OSEA**
No requirere preparacion.