Beaumont

PATIENT INFORMATION - Division of Breast Imaging

Type of Exam: ☐ Mammogram ☐ Procedure/Biopsy ☐ Ultrasound ☐ Breast MRI

CURRENT SYMPTOMS ☐ NONE

R	L	
○	○	Breast Pain of Concern
○	○	General Lumpiness
☐	☐	Lump, felt by patient Date: _____
☐	☐	Lump, felt by physician Date: _____
☐	☐	Nipple discharge, clear or bloody
☐	☐	Nipple inversion ☐ New ○ Chronic
☐	☐	Skin thickening/retraction
☐	☐	Breast infection/Abscess
☐	☐	Abnormal mammogram or ultrasound, follow-up
☐	☐	Symptoms of implant rupture
○	○	Other: _____

PREVIOUS TREATMENT ☐ NONE

R	L			
○	○	Cyst Aspiration		
○	○	Reduction	Year_____	
○	○	Implants	Year_____	☐ silicone ☐ saline
○	○	*Biopsy	Year_____	Result_____

HISTORY OF BREAST CANCER ☐ NONE

R	L		
☐	☐	Currently being treated for breast cancer	
☐	☐	Lumpectomy Less than 2 Years Ago	
○	○	*Lumpectomy More than 2 Years Ago	
○	○	*Mastectomy	
○	○	*Radiation Therapy	Year Completed _____
○	○	*Reconstruction	Type:_____

FAMILY HISTORY OF BREAST CANCER ☐ NONE

- ○ Mother — Age at Diagnosis _____
- ○ Sister — Age at Diagnosis _____
- ○ Daughter — Age at Diagnosis _____
- ○ Aunt — Age at Diagnosis _____
- ○ Grandmother — Age at Diagnosis _____
- ☐ Other_____

CURRENT MEDICATION ☐ NONE

- ○ Estrogen — # of Years_____
- ○ Progesterone — # of Years_____
- ○ Birth Control — # of Years_____
- ○ Thyroid Replacement — # of Years_____
- ○ Tamoxifen — # of Years_____

MENSTRUAL HISTORY

Last Menstrual Period _____

Age when menstruation stopped _____

○ Natural ○ Surgical

PREVIOUS MAMMOGRAMS ☐ NONE

- ○ Beaumont - year_____
- ○ Outside Facility (complete and sign back of page)

Please list phone numbers at which we can contact you, if necessary.

Home: _____ Work: _____

Cell: _____ Other: _____

PATIENT HISTORY OF CANCER (Other than Breast)

Type: _____ Chest/Neck Radiation ☐ Yes ☐ No

I attest that to the best of my knowledge the above information is correct.

PATIENT SIGNATURE: _____ DATE: _____

FOR TECHNOLOGIST USE ONLY **FOR TECHNOLOGIST USE ONLY**

TECH COMMENTS: ☐ NO COMPLAINTS

_____

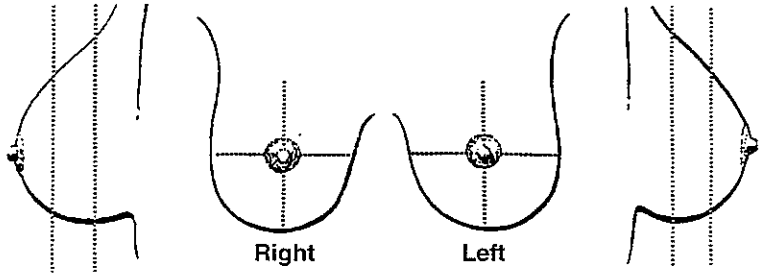
_____

_____

_____

_____

_____Tech Initials:_____



☐ *Can be a screening examination if the patient has **no symptoms** and the referring MD or patient **specifically request** a screening exam. Check box.

AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

Only complete if you have outside films

Patient's Name _____ Date of Birth _____
LAST PLEASE PRINT FIRST

Patient Number: _____

hereby authorizes:

_____ _____
BREAST CENTER RELEASING INFORMATION BREAST CENTER RELEASING INFORMATION

_____ _____
ADDRESS ADDRESS

_____ _____
CITY/STATE/ZIP CITY/STATE/ZIP

its Director or designee, or Medical Information Services Department to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological services records, and if, and social work records, if any, including communications made by me to a social worker or psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any, to the individuals or organizations listed below, only under the conditions listed below:

1. Name of person(s) or organization(s) to whom disclosure is to be made (indicate one):

☐ Beaumont Hospital, Royal Oak
Imaging Center
3601 W. 13 Mile Road
Royal Oak, MI 48073-6769
Phone: 248-551-7531
Fax: 248-551-1850

☐ Beaumont Hospital, Troy
44201 Dequindre
Troy, MI 48085
Phone: 248-964-7050 (film room)
Fax: 248-964-5839

☐ Beaumont Hospital, Grosse Pointe
468 Cadieux Road
Grosse Pointe, MI 48230
313-473-1631 (radiology administration)
313-473-1896 (film room)
313-473-1289 (fax)

2. Specific type of information to be disclosed: *(if the Radiologist requests)*

☐ Please transfer all of my mammogram and breast ultrasound films and reports to the Beaumont facility indicated above. They will be kept **at Beaumont** for comparison to my current and future studies. I will notify **Beaumont** if and when I want them transferred to another facility.

☐ Please transfer all of my mammogram and breast ultrasound films and reports to the Beaumont facility indicated above. I would like them transferred back to the original facility as soon as the comparison is made.

3. This authorization is subject to written revocation at any time except to the extent that William Beaumont Hospital has already taken action in reliance on the authorization. This authorization will expire upon disclosure of requested information.

Signature of Patient/
Authorized Representative _____ Date_____
(If authorized representative signature, include paperwork.)

Signature of Parent/Guardian _____ Date_____

Signature of Witness _____ Date_____