

PATIENT NAME: _____ UMHC #: _____

PHYSICIAN / ARNP: _____

INDICATION:

MASS	R _____	L _____
CALCIFICATION	R _____	L _____
ASYMMETRY	R _____	L _____
OTHER (SPECIFY)	R _____	L _____

FILMS MARKED: Y / N

IF MASS, ULTRASOUND OBTAINED? Y / N

COMMENTS: _____

BIOPSY TYPE RECOMMENDED:

MAMMOGRAPHIC LOCALIZATION	_____
ULTRASOUND LOCALIZATION	_____
STEREOTACTIC BIOPSY	_____
ULTRASOUND GUIDED FNA/CORE	_____
MAMMOTOME	_____

RECOMMENDED BY: _____ DATE: _____
RADIOLOGIST

APPROVED BY: _____ DATE: _____
RADIOLOGIST

SURGEON DATE: _____

SCHEDULE DATE: _____ BY: _____

All original UMSylvester medical records are the property of UMSylvester and maintained by the Health Care Provider's Record Custodian. Copies of this form must be destroyed upon the completion of its temporary use. To receive a copy of your health information please contact your Health Care Provider's Record Custodian or the UMSylvester HIM Release of Information department at (305) 243-5272.

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HOSPITAL & CLINICS
Miami, FL 33136 www.med.miami.edu (305)243-1000

MAMMOGRAPHY NEEDLE LOCALIZATION BIOPSY APPROVAL

NAME: _____

_____ UMMG # MRN

AGE: _____ DOB: _____ / _____ / _____

DATE OF SERVICE: _____



Form
A1400011

Revised
03/10/05