OVERLAKE BREAST CENTER

Phone: (425)688-5985 ● Fax: (425)688-5710

Overlake Breast Diagnostic and Screening Center
1135 116th Ave NE Suite 200
Bellevue WA 98004

Overlake Breast Screening – Issaquah
1740 NW Maple St Suite 207
Issaquah WA 98027

Patient First Name_____ Patient Last Name_____ DOB _____

Phone Number _____ Insurance Carrier & ID #_____

SCREENING:

- ☐ **Mammogram** – no symptoms or clinical findings in either breast (referral not needed)
- ☐ **Supplemental Ultrasound** – dense breast tissue; elevated lifetime risk for breast cancer (ABUS or US complete)

DIAGNOSTIC:

- ☐ **Diagnostic Evaluation** – May include the following: Mammography (new issue), Ultrasound (limited), cyst aspiration, percutaneous core needle biopsy or galactography
- ☐ **Breast MRI**

FOLLOW UP:

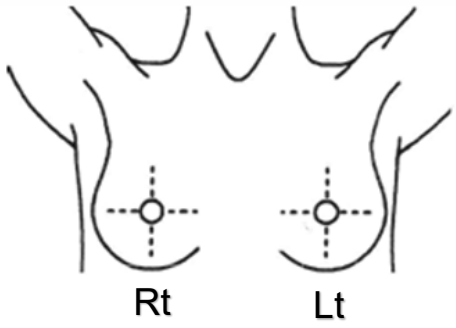
- ☐ **Mammogram** (Rt, Lt, Bil) 3, 6, 9,12 month diagnostic
- ☐ **Ultrasound** (Rt, Lt, Bil) 3, 6, 9,12 month diagnostic

ICD-10 CODE REQUIRED

- ☐ Palpable lump/duration ☐Rt ☐Lt ☐Bil _____
- ☐ Thickening/duration ☐Rt ☐Lt ☐Bil _____
- ☐ Pain/tenderness ☐Rt ☐Lt ☐Bil _____
- ☐ Nipple discharge ☐Rt ☐Lt ☐Bil _____
- ☐ Nipple inversion ☐Rt ☐Lt ☐Bil _____
- ☐ Mastitis ☐Rt ☐Lt ☐Bil _____
- ☐ Axillary Lymphadenopathy ☐Rt ☐Lt ☐Bil _____
- ☐ Implants evaluation ☐Rt ☐Lt ☐Bil _____
- ☐ Prior breast Cancer ☐Rt ☐Lt ☐Bil _____year

ICD-10 CODE(S)_____

Please mark area of concern:



Distance from nipple ____cm size _____cm

Referring Physician Name (Please print)_____ Office Contact_____

Referring Physician Signature_____ Date_____ Time_____

OVERLAKE MEDICAL CENTER & CLINICS
MultiCare

BREAST CENTER REFFERAL PAD
A0786C *1031* (Rev 8/26)

Place Patient Label Here