# HAWAII RADIOLOGIC ASSOCIATES, LTD.

## WOMEN'S IMAGING SERVICES

HILO OFFICE: 1285 Waianuenue Avenue • Hilo, Hawaii 96720 • Phone: (808) 961-4745 • Fax (808) 933-2532
KONA OFFICE: 77-311 Sunset Drive • Kailua-Kona, Hawaii 96740 • Phone: (808) 329-7314 • Fax (808) 329-5510

| PATIENT NAME (LAST, FIRST, M.I.) | SEX ❑ M ❑ F | DATE OF BIRTH | PATIENT SOC. SEC. NO. |
|---|---|---|---|
| | | | |

| ADDRESS / CITY / STATE / ZIPCODE | HOME / TELEPHONE / WORK |
|---|---|
| | |

| DATE OF EXAM: | APPOINTMENT TIME: | PREP: |
|---|---|---|
| | | |

| DATE OF INJURY/PREGNANCY (LMP) / / | ACCIDENT: ❑ WORK ❑ AUTO ❑ OTHER | DESCRIPTION OF ACCIDENT |
|---|---|---|
| | | |

| KNOWN ALLERGIES: | ❑ ROUTINE REPORT | ❑ PHONE REPORT TO DR. _____ AT _____ |
|---|---|---|
| | | |

REFERRING DOCTOR'S SIGNATURE: DATE:
X

Inform patient to have available: _____ Medical insurance card _____ Medicare card _____ Personal payment

Medicare only pays for tests that it considers medically necessary to make a diagnosis or treat a patient. Generally, tests for screening purposes (screening mammography and dexa have certain exceptions) are not considered medical necessary. If you are ordering a test that may not be covered, then you should disclose that fact to the patient and have him or her sign an Advanced Beneficiary Notice (ABN).

### ❑ SCREENING MAMMOGRAPHY

❑ If further views are clinically warranted then authorization is given to schedule or proceed to a diagnostic breast evaluation, which may include diagnostic mammography and/or ultrasound as indicated

### CLINICAL INFORMATION
*(Please check one & illustrate in diagram)*

- ❑ Asymptomatic patient/routine exam
- ❑ Baseline exam
- ❑ augmentation implants, no clinical concerns
- ❑ Family history, no clinical concerns
- ❑ Previous negative biopsy, no clinical concerns

### DIAGNOSTIC BREAST EVALUATION

❑ **DIAGNOSTIC MAMMOGRAPHY**

- ❑ With Further Ultrasound or Non-invasive Breast Work-up if Needed as Determined by Breast Center Radiologist
- ❑ Percutaneous Aspiration and/or Biopsy if indicated by Clinical and Imaging Criteria

- ❑ Ultra High Resolution Ultrasound
- ❑ Preoperative Breast Localization
- ❑ Galactography
- ❑ Please send a copy of any diagnostic or pathology reports to the following clinician or breast care specialist:_____
- ❑ If a biopsy is indicated by imaging criteria, please forward the films and a copy of the diagnostic reports to Dr. _____ for surgical consultation.

- ❑ Bilateral
- ❑ Right
- ❑ Left

*(Please check one & illustrate in diagram)*

**ILLUSTRATE: O = LUMP X = PAIN**

Right Left Right Left

- ❑ localized tenderness
- ❑ palpable lump or thickening
- ❑ augmentation implants, with clinical concerns
- ❑ previous positive lumpectomy or mastectomy
- ❑ nipple discharge
- ❑ abnormal mammogram follow-up

### ULTRASOUND SERVICES

- ❑ Abdominal Ultrasound-Complete
- ❑ Abdominal Ultrasound-Limited
- ❑ Pelvic Ultrasound (Transabd and Endovag)
- ❑ OB Ultrasound-Complete
- ❑ OB Ultrasound-Limited
- ❑ Amniocentesis Guidance
- ❑ Biophysical Profile
- ❑ Sonohysterography
- ❑ Renal Ultrasound
- ❑ Thyroid Ultrasound
- ❑ Other_____

### DEXA BONE DENSITOMETRY

- ❑ Post-Menopausal
- ❑ Pre-Menopausal

Dx:_____

_____

_____

### CLINICAL INFORMATION
**ULTRASOUND AND DEXA**
**SIGNS/SYMPTOMS (ICD-9 CODES)**

_____

_____

_____

_____

_____

_____

_____

Form
11/00

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient:_____

Pursuant to Chapter 323-C, Hawaii Revised Statutes, I hereby authorize HAWAII RADIOLOGIC ASSOCIATES, LTD. to disclose my health information, including copies of medical records to: (a) any health insurance plan or company that provides insurance coverage for me or the named patient, for the purpose of payment of charges; (b) any insurance company that provides liability insurance to HAWAII RADIOLOGIC ASSOCIATES, LTD., to evaluate clinical performance; (c) any workers' compensation, no-fault or administrative proceeding for the purpose of evaluating my medical condition; (d) any provider that is federally mandated under MQSA regulations; (e) to _____ for the purposes of _____.

- This authorization shall cover the period of time from my first visit to my last visit.
- I understand that I can revoke this authorization at any time.
- This authorization shall end two years after the date of my last visit.

Name and relationship
of person signing, if not patient:_____

Signed: _____ Date: _____